

The Equitable Healthcare Survey

OPTIONS FOR CONTROLLING COSTS

**A Survey of the American Public
and Selected Professionals
in the Health Care Field**

conducted for
The Equitable Life Assurance Society of the
United States

by Louis Harris and Associates, Inc.

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INTRODUCTION

The inflation of health care costs and expenditures is now one of the most important and most seriously debated problems facing the nation. Both public and private spending on health care have grown much faster than the economy, and much faster than anyone anticipated. Total national health care spending has gone from \$51 billion in 1967 to more than \$300 billion in 1982. In the past year alone, health care costs rose 11.9%, while the consumer price index rose only 3.9%. Health care spending now accounts for over 10% of the gross national product. Policymakers in government and business have been grappling with this problem for the last several years with very little success. The search for new and better policies to contain the high cost of health care is likely to grow even more intense. This survey is designed to help both the government and the private sector in this very difficult task.

There is no shortage of ideas and proposed solutions. These include making changes in the third-party payment system, increasing price competition among health care providers, instituting new controls and regulations on health care services, encouraging health promotion and wellness programs, or educating the public on health care costs and programs.

Although the subject has had great visibility and numerous surveys have shown a high level of general public concern, until now no survey has looked in any detail at the likely reactions of the public, employers, unions, health care providers, and the health insurance industry to the range of options now being debated. The absence of any such survey was a remarkable omission when one recognizes that no new policy will work unless it is acceptable to the American people and changes in significant ways the motives and behavior of health care users and health care providers. To fill that gap, this survey was designed by Louis Harris and Associates and sponsored by The Equitable Life Assurance Society of the United States.

The following groups were surveyed in order to obtain the opinions of a wide range of participants in the health care system:

- A national cross section of 1,501 adults;

- A national sample of 100 physician leaders; that is, physicians who head local, state, and specialty medical societies;
- A sample of 100 hospital administrators, representing the largest hospitals across the nation;
- A sample of 50 senior health insurance executives of the larger insurance companies throughout the nation;
- A sample of 250 corporate benefits officers from companies in the *Fortune* lists of the largest industrial and nonindustrial companies; and
- A national sample of 26 union leaders who are responsible for health care benefits within major trade unions.

The details of the sampling procedure are presented in Appendix A.

Survey Content

Topics explored in the survey are outlined below:

- General attitudes toward the health care system in the U.S. and the system's particular strengths and weaknesses;
- Perception of the reasons for health care cost escalation and possible solutions;
- Attitudes toward a broad range of cost-containment policies and programs in terms of their anticipated effectiveness and acceptability; and
- Attitudes toward various proposed trade-offs between better coverage on the one hand and greater cost to the patient on the other.

In addition, the nationwide sample of the American public was asked a few questions about their utilization of and experience with health care services and health care coverage. The corporate benefits officers and union leaders were also asked a few questions about the health care benefits offered by their organizations and their experience with various cost-containment programs.

A Note on the Tables

Percentages in the tables may add up to more than 100% because of rounding or the acceptance of multiple responses. On the other hand, percentages in the tables may add up to less than 100% because of the exclusion of "not sure" responses. All tables show unweighted percentages for the professional groups and weighted percentages for the public sample, and they indicate the bases on which the responses are percentaged.

In order to limit the length of this report, some of the replies to a very few questions (which either confirm the findings discussed in the report or reveal no intergroup differences) are omitted.

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SURVEY HIGHLIGHTS

This summary provides an overview of the highlights of this survey. As with any large-scale study of this type, many important details are not reported in the summary. Interested readers are urged to examine the full report.

1. There is a general consensus that fundamental changes are needed to make the U.S. health care system work better.

The American public, by a three-quarters majority, views the U.S. health care system as needing major changes. This view is shared by large majorities of employers, insurance executives, and unions, and by a marginal majority of hospital administrators. The one exception to this consensus lies with the medical profession: a clear majority of physicians who head medical societies believe that the health care system works pretty well and that only minor changes are needed to improve it.

2. The American public views both the cost of and access to health care services as areas in need of change.

Cost-related and access-related changes head the list of changes in the health care system considered most important by the American public and union leaders. The other professional groups acknowledge the need for cost-related changes, but they also emphasize public education regarding medical programs and costs. The primary change sought by physician leaders is less government interference and regulation.

The public's concern about access centers around care for the elderly. Based on their personal experiences, however, the American people, including the elderly, are largely satisfied with the quality of and access to health care services, and with health insurance benefits.

3. Barriers to medical care.

The 14% of the American public who did not obtain needed medical care in the twelve months preceding this survey include sizable numbers of the uninsured (32%) and the unemployed (28%). The primary barrier to obtaining needed medical care is the cost of this care.

4. There is widespread dissatisfaction with the cost of hospitalization.

While a slight majority of the American public are dissatisfied with the total cost of health care as well as out-of-pocket costs, their criticisms are focused mainly on the cost of hospitalization and the cost of laboratory work and X-rays done outside hospitals and clinics. Smaller majorities of the public also consider the cost of doctors' visits and prescription drugs to be unreasonable.

The view that hospital costs are unreasonable is shared by an overwhelming majority of union leaders, corporate benefits officers, and insurance executives, and by a significant majority of physician leaders. Even among hospital administrators, 40% view hospital costs as unreasonable.

5. There is very little consensus on the main cause of increased spending on health care.

The debate about the main underlying cause of the escalation of health care spending is still unresolved. While slightly more than 40% of the American people view this escalation as due to "the increasing cost of the same services," one-third of this group blame "the use of new and more expensive treatments and equipment." Physician leaders and hospital administrators view the latter reason as the primary cause of escalating expenditures.

"People using more services than they used to" is not acknowledged as a major cause of escalating expenditures by the American public. However, about 30% of physician leaders and hospital administrators recognize it as a primary cause of this escalation.

The views of corporate benefits officers and union leaders tend to parallel those of the public.

6. The health care system as it is today does little to encourage price competition.

Only 16% of the American public have selected a doctor because of lower fees. Comparison shopping for prescription drugs is viewed as easier than shopping for health insurance, doctors, or hospitals. Shopping for laboratory tests and X-rays is viewed as difficult by a sizable majority of the American public.

7. The lack of price competition in the system is acknowledged as a reason for the rise in health care spending.

Large majorities of the American public and of all of the professional groups *except* the physician leaders agree that "the lack of competitive pricing among doctors, hospitals, or nursing homes" contributes to the rise in health care spending.

The opinions of physician leaders contrast sharply with those of all of the other groups, including hospital administrators. While only 37% of the physician leaders blame "lack of price competition" for the increase in health care spending, 68% of hospital administrators do so.

On the other hand, there is general consensus that as long as third-party payers assume all or most of the cost of health care, there is no incentive for patients or providers to cut spending or costs.

8. The American people and most professionals recognize that programs and practices that benefit them are also a source of inflation in health care spending.

Majorities in all groups mention the following as contributing to cost escalation: the increased availability of employer-paid health insurance, hospitalization for minor ailments, the growth of malpractice suits, people staying in hospitals longer than is necessary, the aging of the population, increased availability of government funded programs, and overuse of tests by doctors.

Physician leaders, in general, are least willing to recognize the actions of their own profession as contributing to the rise in health care spending, while hospital administrators have a more balanced view. While majorities of respondents in all groups recognize that "one of the problems in health care is that there is no real competition to keep prices down," only 27% of the physician leaders agree with this view.

9. The American public is ready to accept a broad range of cost-containment proposals.

The conventional wisdom that the American public will resist major changes in the health care system is called into question by the findings of this study.

The American public is remarkably willing to accept a broad range of cost-containment policies, including those that would increase out-of-pocket costs to the public and minimally curtail freedom of choice among health care options.

This willingness to accept proposed changes is based on the belief that the changes will be effective in slowing health care cost inflation. These findings suggest that the public would be willing to accept such changes because of a sense of realism and an understanding that the changes are necessary, rather than because they support them enthusiastically.

The proposals that the public considers most acceptable are: alternatives to the use of hospitals for minor surgery, tests, or the treatment of the chronically ill, increased cost-sharing in the payment of health insurance premiums and increased deductibles, diagnosis-related cost caps on hospital and doctors' fees, requiring second opinions on non-emergency surgery, insurance rate incentives for preventive care, prepaid plans and preferred provider plans, and using low-cost alternatives to physicians and hospital care.

10. Professional groups have varying perspectives on the cost-containment proposals.

Union leaders, corporate benefits officers, and insurance executives generally share the views of the American public, and they are willing to accept almost all of the proposed changes in the health care system.

Hospital administrators are generally willing to accept changes in the health care system in the interest of cost containment, even if the changes mean a reduction in hospital use or a restriction on the fees charged by hospitals.

Physician leaders are the least willing of all groups surveyed to accept — or even to recognize as effective — changes that are likely to adversely affect the financial incentives for their profession.

11. Most corporate executives whose companies have implemented new cost-containment programs believe that the programs are effective.

Corporate executives whose organizations have had experience with various cost-containment measures are more likely to judge them as effective than are those who have had no experience with these measures. This is particularly true for programs that require increased cost-sharing by employees and for those that provide better coverage for lower cost health care options, such as home care for the chronically ill and the use of nurse practitioners, midwives, and physicians' assistants.

12. There is widespread opposition to a proposed tax on employer-paid premiums.

One policy that is rejected by the majority of respondents in most groups as ineffective and unacceptable as a cost-containment measure is the often-discussed individual tax on a portion of the employer-paid health insurance premiums.

The physician leaders are the only group in which a clear majority find this proposal to be both effective and acceptable.

13. Shifting costs from Medicare patients to other patients is viewed with disfavor.

The majority of the American public and majorities of all of the professional groups disapprove of the practice of shifting costs from Medicare patients to other patients. This disapproval is voiced as strongly by those who do receive Medicare benefits as those who do not.

14. There is general support for programs that provide health insurance for the unemployed, but it diminishes sharply when viewed as resulting in greater costs for other people.

The American people (including the unemployed) and corporate benefits officers reveal a marginal reluctance to support health care benefits for the unemployed if such benefits result in higher direct or indirect costs to other people. However, sizable minorities (of more than 40%) are in favor of these benefits despite their costs.

Physician leaders, insurance executives, and hospital administrators, on the other hand, favor providing these benefits.

15. Overall, the American public reveals awareness of and concern about health care issues.

The majority of the American public are remarkably aware of and concerned about problems related to health care coverage and health care services. This is reflected in the relatively insignificant numbers of respondents who give 'not sure' or 'no opinion' responses to the questions asked in this survey.

CHAPTER 1: GENERAL ATTITUDES TOWARD THE HEALTH CARE SYSTEM

Overall View of the Health Care System

A majority of the American public (75%) view the health care system in this country as needing major changes (Table 1-1).¹ In choosing the one statement among three that best expresses their view of the health care system, 50% say "there are some good things in our health care system, but fundamental changes are needed to make it work better." This view is shared by a majority of health insurance executives (80%), corporate benefits officers (79%), union leaders (69%), and hospital administrators (56%). While 25% of Americans view the health care system as having "so much wrong with it that we need to completely rebuild it," small minorities of the professional groups (2% to 12%) hold this view.

The views of physician leaders are remarkably different from those of the other groups: 32% say the health care system needs "fundamental changes to make it work better"; none of the physician leaders see a need to "completely rebuild it"; and the majority (68%) feel that "on the whole, the health care system works pretty well, and only minor changes are necessary to make it work better." This latter view is held by 21% of the American public, 41% of hospital administrators, 19% of union leaders, 16% of insurance executives, and 12% of corporate benefits officers (Table 1-1).

Older Americans (30% or more of those aged 40 and over), the retired (34%), the unemployed (30%), the uninsured (38%), those in fair or poor health (35%), and those with Medicare coverage (30%) are most likely to see a "need to completely rebuild" the health care system (Tables 1-2, 1-3, and 1-4).

Observation:

Health care providers seem to have the most favorable view of the American health care system. Physician leaders are most likely to be content with the status quo, while hospital administrators are likely to be somewhat more critical of the system. Clearly, these views are colored by the extent to which the present health care system serves the interests of the groups interviewed.

¹ Similar findings were obtained in a survey of the American public conducted for the Robert Wood Johnson Foundation on "Access to Health Care Services in the United States" (Summer 1982).

Table 1-1

**OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM:
THE PUBLIC AND PROFESSIONALS COMPARED**

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	21	68	41	16	12	19
There are some good things in our health care system, but fundamental changes are needed to make it work better	50	32	56	80	79	69
The American health care system has so much wrong with it that we need to completely rebuild it	25	-	2	4	8	12
Not sure	4	-	1	-	1	-

Table 1-2

OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM: THE PUBLIC BY AGE

Base: Public cross section

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

	Total	Age				
		18-29 Years	30-39 Years	40-49 Years	50-64 Years	65 and Over
No. of Respondents	1501	400	358	208	305	225
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	21	20	21	22	20	22
There are some good things in our health care system, but fundamental changes are needed to make it work better	50	64	53	43	45	33
The American health care system has so much wrong with it that we need to completely rebuild it	25	14	24	31	33	30
Not sure	4	2	2	3	1	15

Table 1-3

OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM:
THE PUBLIC BY OCCUPATIONAL STATUS

Base: Public cross section

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

	Total	Occupational Status				
		Employed Full-Time	Employed Part-Time	Retired	Unemployed	Student/ Housewife
No. of Respondents	1501	800	159	272	88	172
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	21	20	22	21	26	22
There are some good things in our health care system, but fundamental changes are needed to make it work better	50	54	55	34	37	62
The American health care system has so much wrong with it that we need to completely rebuild it	25	23	22	34	30	14
Not sure	4	3	1	10	6	1

Table 1-4

**OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM:
THE PUBLIC BY HEALTH STATUS AND INSURANCE COVERAGE**

Base: Public cross section

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

	Total	Health Status		Type of Health Care Coverage				
		Excellent/ Good	Fair/ Poor	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1253	247	1016	300	94	687	75
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	21	21	20	22	23	25	21	13
There are some good things in our health care system, but fundamental changes are needed to make it work better	50	53	38	52	37	39	51	42
The American health care system has so much wrong with it that we need to completely rebuild it	25	23	35	23	30	26	24	38
Not sure	4	3	8	3	10	10	4	7

Suggested Changes for the Health Care System

The major areas of concern about the American health care system are cost and access. Most of the changes in the system that are widely desired relate to cost or access or both.

Table 1-5 indicates the changes the groups suggested spontaneously when they were asked for the *one* change they would make in the U.S. health care system. Cost-related changes are suggested by 31% of union leaders, 28% of corporate benefits officers, 24% of insurance executives, 23% of the American public, 19% of hospital administrators, and only 14% of the physician leaders. Access-related (and indirectly, cost-related) changes are of most interest to the American public (24%) and union leaders (23%).

The length of the list of suggested changes presented in Table 1-5 indicates that the American public and the professional groups have varied and wide-ranging concerns about the health care system. Only the changes suggested most frequently within each group are highlighted in the text that follows.

• American Public

- 'Control or limit costs' (12%);
- 'More or better care for the elderly, more inclusive Medicare' (11%);
- 'Socialized medicine or national health service' (8%);
- 'Lower hospital costs' (5%);
- 'Assure availability of equal quality care for all' (5%); and
- 'For those who can't afford it, cut costs or provide financial support' (5%).

Clearly, the professional groups interviewed have varying priorities for change. The suggestions made most frequently within each professional group are:

• Physician Leaders

- 'Less government interference/regulation' (15%);

- 'Public education regarding medical programs and costs' (13%);
- 'People should pay more of the cost of health care' (8%); and
- 'Control/limit costs' (8%).

• Hospital Administrators

- 'Control/limit costs' (13%);
- 'Need better insurance coverage, or reevaluate coverage' (8%); and
- 'Change fee for service system to capitation/prospective payment' (8%).

• Insurance Executives

- 'Control/limit costs' (16%);
- 'Public education regarding medical programs and costs' (10%);
- 'Change fee for service system to capitation/prospective payment' (8%); and
- 'Need better insurance coverage/reevaluate coverage' (8%).

• Corporate Benefits Officers

- 'Control/limit costs' (18%);
- 'Public education regarding medical programs and costs' (12%).

• Union Leaders

- 'Socialized medicine, national health service' (31%);
- 'Control/limit costs' (15%);
- 'Assure availability of equal quality care for all' (12%);
- 'Lower hospital costs' (8%); and
- 'More or better care for the elderly, more inclusive Medicare' (8%).

The data on suggested changes are fairly uniform across the various subgroups within the American public and therefore are not detailed here.

The suggestions for change in the health care system mentioned by the American public have not changed substantially since 1980, as is evident in the data presented in Table 1-6. However, the priorities have shifted marginally, with concern about access to health care having increased, and concern about cost having declined. The increased public concern about access is focused on the elderly and Medicare.

Observation:

Data reported elsewhere in this report (Table 1-7) suggest that the interest in the cost issue is based on a personal dissatisfaction with both the total and the out-of-pocket costs of health care. On the other hand, additional data (Tables 1-7 and 1-15) reveal that access to health care services is not a problem for the majority of the American public. Thus, it appears that the interest in access-related changes may reflect either a concern for that small segment of the population who do have access problems, or it may be based on a mistaken perception of the extent of the access problem.

The distinction between cost and access is important wherever policies designed to reduce or control costs could also diminish ease of access to health care services.

Table 1-5

**SUGGESTED CHANGES IN THE U.S. HEALTH CARE SYSTEM:
THE PUBLIC AND PROFESSIONALS COMPARED**

Q. If there were *one* change you could make in the health care system in the United States, what would it be?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Cost-Related Changes (Total)	23	14	19	24	28	31
Control or limit costs	12	8	13	16	18	15
Lower hospital costs	5	2	-	2	6	8
Reduce doctors' charges	4	2	3	6	3	4
Government should cover health care/insurance costs	2	2	3	-	-	4
Access-Related Changes (Total)	24	13	17	8	8	23
More/better care for the elderly, more inclusive Medicare	11	-	-	-	-	8
Assure availability of equal quality care for all	5	4	2	-	1	12
For those who can't afford it, cut costs/provide financial support	5	3	7	-	2	-
Need better insurance coverage, reevaluate coverage	3	6	8	8	4	4
Other Specific Reasons						
Socialized Medicine, national health service	8	-	5	2	1	31
Less impersonal doctor/patient relationship	3	6	3	-	-	-
Preventive medicine should be implemented/augmented	2	3	2	4	3	-
Eliminate waste/fraud/graft/pilfering/handouts	2	-	4	2	1	4
Better hospitals — care, attitudes, integrity	2	1	-	2	1	-

Continued

Table 1-5 (Continued)

**SUGGESTED CHANGES IN THE U.S. HEALTH CARE SYSTEM:
THE PUBLIC AND PROFESSIONALS COMPARED**

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Other Specific Reasons (Continued)						
Public education regarding medical programs and costs	2	13	4	10	12	4
More research, find cures	2	1	2	-	-	-
More doctors/students in medical schools	2	1	2	-	1	-
People should pay more of the cost of health care	1	8	6	2	6	-
Eliminate unnecessary use of facilities/Medicaid/ Medicare	1	1	-	6	6	-
Better doctors: responsibility, proficiency, attitude	1	-	2	4	1	-
Less government interference/ regulation	1	15	6	2	2	-
Investigate/regulate insurance companies	1	-	-	-	1	4
Change fee for service system to capitation/ prospective payment	1	2	8	8	4	-
More investigation of third- party reimbursement	-	6	3	6	2	-
Increase competition between doctors	-	-	1	2	3	-
Increase formation/ use of HMO's	-	1	3	-	2	-
Utilization/peer review	-	1	-	4	1	-
All Other Reasons Mentioned (Total)	6	3	9	14	10	4
Don't know, not sure	18	5	2	2	9	-

*Less than 0.5%.

Table 1-6
SUGGESTED CHANGES IN THE U.S. HEALTH CARE SYSTEM: TRENDS

Base: Public cross section

Q. If there were *one* change you could make in the health care system in the United States, what would it be?

No. of Respondents	Total	
	May/June 1983	October 1980 ¹
	1501	1538
	%	%
Cost-Related Changes (Total)	23	30
Control/limit costs	12	10
Lower hospital costs	5	4
Reduce doctors' charges	4	6
Government should cover health care/insurance costs	2	4
Make it less expensive (nonspecific)	-	6
Access-Related Changes (Total)	24	17
More/better care for the elderly, more inclusive Medicare	11	7
Assure availability of equal quality care for all	5	4
For those who can't afford it, cut costs/provide financial support	5	5
Need better insurance coverage, reevaluate coverage	3	1
Other Suggested Changes²		
Socialized Medicine, national health service	8	7
Less impersonal doctor/patient relationship	3	4
Preventive medicine should be implemented/augmented	2	1
Eliminate waste/fraud/grat pilfering/handouts	2	2
Better hospitals — care, attitudes, integrity	2	2*
Public education regarding medical programs and costs	2	-
More research, find cures	2	1
More doctors/students in medical schools	2	3

¹ Source: 1980 Lou Harris Perspective: Healthcare

² Only specific suggestions mentioned by 2% or more of the sample are reported in this table.

Satisfaction and Dissatisfaction With Health Care

High levels of satisfaction with the quality and availability of health care and with health insurance benefits contrast sharply with widespread dissatisfaction with both the total and the out-of-pocket costs of health care.

Respondents in all groups were asked to indicate how satisfied or dissatisfied they are with specific aspects of health care. These data are presented in Table 1-7.

Interesting differences are evident in the extent of satisfaction with specific aspects of health care expressed by the various groups interviewed. While 88% or more of the respondents from the professional groups are very or somewhat satisfied with the quality of health care, generally, only 77% of the American public are satisfied.

Satisfaction with the availability of health care is lowest among union leaders (62%), followed by that of the general public (75%); more than 85% of the other professional groups express satisfaction with the availability of health care. Satisfaction with health insurance benefits is highest among insurance executives and corporate benefits officers (96% each), followed by that among physician leaders (89%), union leaders (88%), and hospital administrators (79%); it is lowest among the American public (70%).

Although the various groups are collectively least satisfied with the cost of health care (both out-of-pocket cost and total cost), hospital administrators, insurance executives, corporate benefits officers, and union leaders are less satisfied with the total cost than with the out-of-pocket costs.

Over 50% of the American public express dissatisfaction with both types of cost, with the greatest dissatisfaction, not surprisingly, being expressed by those who have no insurance coverage (Table 1-8). This latter group is generally less satisfied with the other aspects of health care as well than are those who have health care coverage. Those in fair or poor health also express greater dissatisfaction with all aspects of health care than is expressed by those in good or excellent health. The former group is particularly dissatisfied with out-of-pocket costs of health care.

Table 1-9 presents the trends in the satisfaction with the various aspects of health care expressed by the American public. While on the one hand the American public has progressively grown less satisfied with the quality of health care generally, on the other hand, they are more satisfied with the total cost of health care (i.e., the cost paid by both the patients and their insurance) than they were in 1978 or 1980.

Table 1-7

**SATISFACTION WITH VARIOUS ASPECTS OF HEALTH CARE:
THE PUBLIC AND PROFESSIONALS COMPARED**

Q. I will mention several different aspects of health care. Please say for each one whether — in the light of your own experience — you are very satisfied with it, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
The availability of health care						
Very satisfied	39	60	49	70	68	27
Somewhat satisfied	36	33	37	28	30	35
Somewhat dissatisfied	16	7	7	2	3	23
Very dissatisfied	7	-	3	-	-	12
The quality of health care generally						
Very satisfied	30	84	58	54	41	23
Somewhat satisfied	47	16	34	42	49	65
Somewhat dissatisfied	14	-	5	4	8	8
Very dissatisfied	6	-	-	-	1	4
Your health insurance benefits						
Very satisfied	37	55	52	74	66	65
Somewhat satisfied	33	34	27	22	30	23
Somewhat dissatisfied	15	7	13	4	2	8
Very dissatisfied	10	4	6	-	1	4
The total cost of health care, including what both you and your insurance pay						
Very satisfied	18	27	17	4	17	19
Somewhat satisfied	28	34	36	20	15	27
Somewhat dissatisfied	25	28	31	40	31	23
Very dissatisfied	25	11	15	36	36	27
The out-of-pocket cost of health care						
Very satisfied	16	26	30	42	39	38
Somewhat satisfied	26	41	37	28	29	31
Somewhat dissatisfied	26	25	22	26	18	19
Very dissatisfied	28	5	11	2	10	12

Table 1-8

**SATISFACTION WITH VARIOUS ASPECTS OF HEALTH CARE:
THE PUBLIC BY HEALTH STATUS AND INSURANCE COVERAGE**

Base: Public cross section

Q. I will mention several different aspects of health care. Please say for each one whether — in the light of your own experience — you are very satisfied with it, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

	Total	Health Status		Type of Health Care Coverage				
		Excellent/ Good	Fair/ Poor	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1253	247	1016	300	94	687	75
	%	%	%	%	%	%	%	%
The availability of health care								
Very satisfied	39	40	34	41	39	39	38	23
Somewhat satisfied	36	36	34	36	33	40	36	43
Somewhat dissatisfied	16	15	19	15	16	11	16	18
Very dissatisfied	7	6	9	6	7	6	7	13
Your health insurance benefits								
Very satisfied	37	39	26	41	35	40	35	x
Somewhat satisfied	33	33	32	35	30	28	36	x
Somewhat dissatisfied	15	14	20	14	17	19	17	x
Very dissatisfied	10	9	14	7	11	6	9	x
The quality of health care generally								
Very satisfied	30	31	26	31	32	21	29	21
Somewhat satisfied	47	47	47	48	44	52	50	47
Somewhat dissatisfied	13	14	14	13	11	19	13	20
Very dissatisfied	6	6	10	6	8	7	6	11
The total cost of health care, including what both you and your insurance pay								
Very satisfied	18	19	14	21	19	21	17	4
Somewhat satisfied	28	28	28	30	29	31	30	12
Somewhat dissatisfied	25	26	24	24	22	22	26	32
Very dissatisfied	25	24	28	22	25	21	24	42
The out-of-pocket cost of health care								
Very satisfied	16	17	10	18	13	14	13	8
Somewhat satisfied	26	26	25	27	27	27	26	12
Somewhat dissatisfied	26	27	22	26	23	21	28	15
Very dissatisfied	28	27	36	25	32	33	28	63

x = This item was not applicable to this group.

Table 1-9

SATISFACTION WITH VARIOUS ASPECTS OF HEALTH CARE: TRENDS

Base: Public cross section

Q. I will mention several different aspects of health care. Please say for each one whether — in the light of your own experience — you are very satisfied with it, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

	Total		
	May/June 1983	October 1980 ¹	December 1978 ²
No. of Respondents	1501	1538	1539
The quality of health care generally			
Very/somewhat satisfied	77	82	87
Very/somewhat dissatisfied	20	15	13
The availability of health care			
Very/somewhat satisfied	75	81	79
Very/somewhat dissatisfied	23	18	20
Your health insurance benefits			
Very/somewhat satisfied	70	69	x
Very/somewhat dissatisfied	25	23	x
The total cost of health care, including what both you and your insurance pay³			
Very/somewhat satisfied	46	28	31
Very/somewhat dissatisfied	50	69	68
The out-of-pocket cost of health care			
Very/somewhat satisfied	42	x	x
Very/somewhat dissatisfied	54	x	x

¹ Source: 1980 Lou Harris Perspective: Healthcare

² Source: 1978 Lou Harris Perspective: Healthcare

³ In 1980, this item was "The cost of health care."

x=Not asked.

Satisfaction and Dissatisfaction With the Cost of Health Care Services

There is widespread dissatisfaction with the cost of hospitalization and a plurality of opinion on the cost of other services. Health care providers are more likely to consider the cost of various services to be reasonable, while union leaders display the greatest dissatisfaction with these costs.

Respondents in all groups were asked how reasonable they considered the cost of various health care services and health insurance (Table 1-10).

Relative to the other items, the American public is most satisfied with the cost of health insurance, which only a scant majority (51%) consider very or somewhat reasonable. The cost of hospitalization is considered unreasonable by a clear majority, while marginal majorities consider the remaining services unreasonable.

The differences in the opinions of the professional groups regarding the cost of the various services are as follows: relative to the other groups the physician leaders are the group most satisfied with all services except hospitalization; union

leaders generally have the most critical views on cost of specific services, particularly the cost of hospitalization and doctors' visits; corporate benefits officers are second only to union leaders in their criticism of hospital and physician costs, but they generally hold moderate views on the cost of other services; hospital administrators are most likely to consider the cost of hospitalization and health insurance reasonable; and insurance executives are primarily critical of hospital costs.

As would be expected, Table 1-11 reveals that while about half the American public considers the cost of health insurance reasonable, only 25% of those without any health care coverage think so. While the difference of opinion is not as great for the other services, the uninsured are least likely to consider any of these services as being of reasonable cost. Those in fair or poor health are more critical of all costs than are those in good or excellent health.

Since 1978, public views on the 'unreasonableness' of the cost of hospitalization have become more widespread; negative views towards the cost of doctors' visits and prescription drugs have risen marginally (Table 1-12).

Table 1-10

**ATTITUDES TOWARD THE COST OF HEALTH CARE SERVICES:
THE PUBLIC AND PROFESSIONALS COMPARED**

Q. Do you think the cost (to you and your household) of (READ EACH ITEM) is very reasonable, somewhat reasonable, somewhat unreasonable, or very unreasonable for what you get?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Health insurance						
Very reasonable	20	17	17	16	12	8
Somewhat reasonable	31	55	49	42	35	27
Somewhat unreasonable	24	25	25	40	34	27
Very unreasonable	20	2	8	2	17	35
Prescription drugs						
Very reasonable	14	15	12	6	2	4
Somewhat reasonable	30	56	39	40	48	23
Somewhat unreasonable	28	21	36	34	36	31
Very unreasonable	26	6	10	20	12	38
Doctors' visits						
Very reasonable	13	35	10	4	2	-
Somewhat reasonable	32	50	47	42	33	15
Somewhat unreasonable	29	12	34	46	47	42
Very unreasonable	22	-	7	8	17	42
Hospitalization						
Very reasonable	11	8	17	2	4	-
Somewhat reasonable	22	27	43	16	13	4
Somewhat unreasonable	27	51	25	46	48	54
Very unreasonable	36	12	15	34	35	42
Laboratory tests and X-rays outside hospitals and clinics						
Very reasonable	9	26	8	6	5	4
Somewhat reasonable	24	48	45	36	39	31
Somewhat unreasonable	29	22	27	46	36	31
Very unreasonable	27	3	9	8	17	31

Table 1-11

**ATTITUDES TOWARD THE COST OF HEALTH CARE SERVICES:
THE PUBLIC BY HEALTH STATUS AND INSURANCE COVERAGE**

Base: Public cross section

Q. Do you think the cost to you and your household of (READ EACH ITEM) is very reasonable, somewhat reasonable, somewhat unreasonable, or very unreasonable for what you get?

	Total	Health Status		Type of Health Care Coverage				
		Excellent/ Good	Fair/ Poor	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1253	247	1016	300	94	687	75
	%	%	%	%	%	%	%	%
Health insurance								
Very reasonable	20	22	13	25	20	18	16	10
Somewhat reasonable	31	31	28	32	29	36	36	15
Somewhat unreasonable	24	23	28	23	22	25	25	17
Very unreasonable	20	19	26	16	23	17	20	43
Prescription drugs								
Very reasonable	14	14	11	16	12	12	12	6
Somewhat reasonable	30	31	22	30	21	27	29	27
Somewhat unreasonable	28	28	25	27	29	35	29	33
Very unreasonable	26	23	38	24	36	22	26	31
Doctors' visits								
Very reasonable	13	14	11	14	14	13	14	6
Somewhat reasonable	32	33	30	34	25	40	32	19
Somewhat unreasonable	29	29	26	28	29	25	30	33
Very unreasonable	22	20	29	21	26	17	21	35
Hospitalization								
Very reasonable	11	11	11	13	10	15	10	5
Somewhat reasonable	22	24	14	23	20	29	24	20
Somewhat unreasonable	27	27	27	26	23	20	29	19
Very unreasonable	36	34	45	33	44	35	35	54
Laboratory tests and X-rays outside hospitals and clinics								
Very reasonable	9	9	9	10	8	14	9	7
Somewhat reasonable	24	24	19	25	21	21	23	20
Somewhat unreasonable	29	30	26	30	26	24	29	30
Very unreasonable	27	26	32	26	29	28	27	36

Table 1-12

ATTITUDES TOWARD THE COST OF HEALTH CARE SERVICES: TRENDS

Base: Public cross section

Q. I will mention several different aspects of health care. Please say for each one whether — in the light of your own experience — you are very satisfied with it, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

No. of Respondents	Total		
	May/June 1983	October 1980 ¹	December 1978 ²
	1501	1538	1539
	%	%	%
Health Insurance			
Very reasonable	20	x	x
Somewhat reasonable	31	x	x
Somewhat unreasonable	24	x	x
Very unreasonable	20	x	x
Doctors' visits			
Very reasonable	13	11	10
Somewhat reasonable	32	35	39
Somewhat unreasonable	29	32	28
Very unreasonable	22	19	18
Prescription drugs			
Very reasonable	14	8	8
Somewhat reasonable	30	32	34
Somewhat unreasonable	28	33	30
Very unreasonable	26	20	20
Hospitalization			
Very reasonable	11	11	12
Somewhat reasonable	22	26	29
Somewhat unreasonable	27	28	25
Very unreasonable	36	26	25
Laboratory tests and X-rays outside hospitals and clinics			
Very reasonable	9	x	x
Somewhat reasonable	24	x	x
Somewhat unreasonable	29	x	x
Very unreasonable	27	x	x

1 Source: 1980 Lou Harris Perspective: Healthcare

2 Source: 1978 Lou Harris Perspective: Healthcare

x = Not asked

Comparison Shopping for Health Care Services

Price sensitivity is not a factor in the selection of a physician. The American public finds it easier to shop around for health care coverage and prescription drugs than for providers.

The data on the ease of shopping for health care services as assessed by the American public are presented in Table 1-13. While about 50% of the public find it very or somewhat easy for consumers to shop around for health insurance, hospitals, and doctors, 67% find it easy for consumers to shop around for prescription drugs, and only 31% find it easy to shop around for laboratory tests and X-rays. These findings are not surprising since physicians are more likely to direct their patients to certain facilities for laboratory work than they are to direct their patients to specific pharmacies or drugstores.

While 49% of the American public consider it easy to shop around for physicians, only 16% have actually selected a doctor because of lower fees (Table 1-14). Again, as would be expected, the uninsured are more likely to have done so than are those with some form of health care coverage.

Table 1-13

EASE OF SHOPPING AROUND FOR HEALTH CARE SERVICES

Base: Public cross section

Q I will read a list of five products and services. Please say, for each one, *how easy or difficult* it is for consumers to check prices and value, in order to *shop around* for the best buy. Is it very easy, somewhat easy, somewhat difficult, or very difficult for consumers to shop around for (READ EACH ITEM)?

	Total
No. of Respondents	1501
Prescription drugs	
Very easy	35
Somewhat easy	32
Somewhat difficult	18
Very difficult	12
Health insurance	
Very easy	24
Somewhat easy	32
Somewhat difficult	24
Very difficult	13
Hospitals	
Very easy	23
Somewhat easy	26
Somewhat difficult	25
Very difficult	21
Doctors	
Very easy	22
Somewhat easy	27
Somewhat difficult	29
Very difficult	19
Laboratory tests and X-rays outside hospitals and clinics	
Very easy	13
Somewhat easy	18
Somewhat difficult	29
Very difficult	31

Table 1-14

SELECTION OF DOCTOR BECAUSE OF LOWER FEES

Base: Public cross section

Q. Other things being equal, have you ever selected a particular doctor because his or her fees were lower than another's, or haven't you?

	Total	Health Status		Type of Health Care Coverage				
		Excellent/ Good	Fair/ Poor	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1253	247	1016	300	94	687	75
Yes, have selected	16	17	15	16	8	17	15	36
No, have not selected	83	82	84	83	91	80	84	64

Barriers to Obtaining Medical Care

Cost is the primary reason that a small minority of the American public did not obtain needed medical care.

Overall, 14% of the American public indicate that there was a time in the twelve months preceding the interviews when someone in the family failed to receive needed medical help (Table 1-15). The percentages that fall into this category are

particularly high among the uninsured (32%), the unemployed (28%), and those that are employed part-time (21%).

The reasons cited most frequently for not obtaining needed medical help is "it cost too much." Forty-five percent of the respondents give this reason, while only 12% and 10% give the next most frequently cited reasons, "not covered by insurance" and "could not get an appointment," respectively (Table 1-16).

Table 1-15
FAMILIES WHO DID NOT GET NEEDED MEDICAL HELP IN THE PAST TWELVE MONTHS

Base: Public cross section

Q. Was there any time in the last year — since (DATE ONE YEAR AGO) 1982 — that you felt you or a member of your family living with you needed medical help but did not get it for some reason?

	No. of Respondents		Yes, There Was a Time	No, There Wasn't a Time
Total	1501		14	86
Health Status				
Excellent/Good	1253		13	86
Fair/Poor	247		18	82
Type of Health Care Coverage				
Through work or union	1016		14	86
Medicare	300		8	92
Medicaid	94		18	82
Other coverage	687		12	87
None	75		32	66
Employment Status				
Employed full-time	800		14	86
Employed part-time	159		21	78
Retired	272		6	93
Unemployed	88		28	71
Student/housewife	172		12	87

Table 1-16

MAIN REASON FOR NOT GETTING NEEDED MEDICAL HELP

Base: Those in the public cross section who did not
obtain needed medical help in the past twelve months

Q. What was the *main* reason that your family did not get the medical help needed in this situation?

	Total
No. of Respondents	219
It cost too much	45
Not covered by insurance	12
Could not get an appointment	10
There was no easy way to get to the doctor's office or clinic	5
Too nervous or afraid	4
Would have had to wait too long in the doctor's office or clinic	3
Did not know a good doctor or clinic to go to	3
Could not get off work	2
Other reasons ¹	13

¹ Each reason was mentioned by one or two respondents.

CHAPTER 2: PERCEIVED REASONS FOR THE INCREASE IN HEALTH CARE EXPENDITURES AND COSTS

Reasons for Increased Health Spending

Health care consumers — the American public, corporate benefits officers, and union leaders — see an increase in the unit cost of health care services as the primary reason for escalating health care costs, while care and coverage providers (physician leaders, hospital administrators, and insurance executives) tend to blame the use of expensive treatments and equipment more than other factors.

When asked to identify which of three general reasons was most responsible for the increase in spending on health care services over the past several years, 44% of the American public cite "the increasing cost of the same services," and 34% cite "the use of new and more expensive treatments and equipment." Only 17% feel that "people using more health care services than they used to" is the main reason for escalating expenditures (Table 2-1).

The views of corporate benefits officers and union leaders generally parallel those of the American public, while those of physician leaders, hospital administrators, and insurance executives are quite different. These latter three groups cite "the use of new and more expensive treatments and equipment" more often than they do the other two reasons as the main reason for escalating expenditures. While insurance executives cite the other two reasons with about equal frequency, physician leaders and hospital administrators cite "people using more health care services than they used to" by more than a 3-to-2 majority over "the increasing cost of the same services."

Table 2-2 indicates the extent to which each of ten specific practices is believed to have contributed to the rise in health care spending. The greatest consensus of opinion is observed in the view expressed by more than 90% of respondents in each group that the "increasing use of expensive new equipment and technology" has contributed very much or somewhat to the increased health care spending in this country.

There is also considerable consensus within each group (77% or more) that "the increased availability of government-funded programs such

as Medicare and Medicaid" and that "the fact that the population as a whole is getting older and older people require more medical services" contribute to the rise in health care spending.

While 80% or more within each of the other samples agree that "doctors ordering more laboratory tests than are necessary" is a contributing factor, only 69% of the physician leaders do so. Similarly, the physician leaders are less likely (37%) than are the other groups (68% to 90%) to cite "the lack of competitive pricing among doctors, hospitals, or nursing homes" as a contributing factor.

Whereas well over half of the respondents in other groups cite "fraud and abuse by some nursing homes, doctors, and hospitals" as contributing factors, less than half the physician leaders (24%) and hospital administrators (42%) do so.

Over 75% of respondents in each group agree that "the growth of expensive malpractice suits which require doctors to pay for malpractice insurance" is a contributing factor, with the physician leaders most likely (91%) to say so.

"Patients being hospitalized for minor ailments that can be treated without hospitalization" and "people staying in hospitals longer than necessary" are cited as reasons for increased spending by more than half of the respondents in all groups. The physician leaders and hospital administrators cite these as contributing factors by smaller margins than do the other groups.

"The increased availability of health insurance provided by employers" is most likely to be viewed as a contributing factor by those who provide it — insurance executives (94%) and corporate benefits officers (93%) — and least likely to be viewed as a contributing factor by those who benefit from it — union leaders (65%) and the public (70%). However, it should be noted that clear majorities in these two groups recognize it as a reason for the rise in health care spending.

Observation

In general, it appears that the physician leaders are least willing to recognize their own actions as being responsible for the rise in health care spending, while the American public recognizes that programs and practices that benefit them are also a source of inflation in health care spending.

Table 2-1

MAIN REASON FOR INCREASED SPENDING ON HEALTH CARE SERVICES

The amount of money spent on health care services has been growing rapidly over the last fifteen years. Total national health care spending has gone from 51 billion dollars in 1967 to over 300 billion dollars last year.

The increased amount of money spent on health care services is partly a result of *people using more health care services than they used to*, partly a result of *the use of new and more expensive treatments and equipment*, and partly a result of the *increasing cost of the same services*.

Q. Which one of these three do you think is the main reason for the increased spending on health care services? I will read the three reasons again if you like.

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
The increasing cost of the same services	44	19	16	26	44	54
The use of new and more expensive treatments and equipment	34	46	49	40	38	27
People using more health care services than they used to	17	31	29	24	15	12
Not sure	4	3	4	10	2	4

Table 2-2

SPECIFIC REASONS FOR THE RISE IN HEALTH CARE SPENDING

Q. I will read you some reasons that are given for the rise in health care spending over the last few years. For each reason, please tell me if you think it has contributed very much, somewhat, not very much, or not at all to the increased health care spending in this country.

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
The increasing use of expensive new equipment and technology						
Very much	50	47	45	46	48	42
Somewhat	40	47	54	52	50	54
Not very much	6	5	1	2	2	4
Not at all	1	-	-	-	-	-
Doctors ordering more laboratory tests than are necessary						
Very much	46	11	26	50	40	46
Somewhat	34	58	54	36	52	46
Not very much	13	28	18	12	8	8
Not at all	4	2	2	2	*	-
The growth of expensive malpractice suits which require doctors to pay for expensive malpractice insurance						
Very much	44	40	20	28	22	23
Somewhat	36	51	64	48	57	54
Not very much	12	9	15	24	20	19
Not at all	4	-	1	-	1	4
The lack of competitive pricing among doctors, hospitals, or nursing homes						
Very much	44	4	29	38	56	58
Somewhat	33	33	39	42	34	27
Not very much	14	42	23	18	8	12
Not at all	5	17	8	2	1	-
Patients being hospitalized for minor ailments that can be treated without hospitalization						
Very much	42	15	25	44	47	27
Somewhat	35	46	39	44	40	42
Not very much	16	32	31	10	11	19
Not at all	4	7	5	2	1	4

Continued

Table 2-2 (Continued)

SPECIFIC REASONS FOR THE RISE IN HEALTH CARE SPENDING

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
The increased availability of government-funded programs such as Medicare and Medicaid						
Very much	37	56	50	60	44	35
Somewhat	42	36	36	36	44	50
Not very much	13	8	10	4	11	15
Not at all	5	-	2	-	1	-
Fraud and abuse by some nursing homes, doctors, and hospitals						
Very much	36	-	6	8	11	23
Somewhat	37	24	36	52	48	54
Not very much	17	67	51	40	38	15
Not at all	3	8	6	-	1	-
The fact that the population as a whole is getting older, and older people require more medical services						
Very much	32	65	52	48	21	38
Somewhat	45	34	39	40	60	54
Not very much	16	1	7	12	18	8
Not at all	5	-	2	-	-	-
People staying in hospitals longer than necessary						
Very much	32	6	8	24	28	12
Somewhat	34	47	46	54	52	69
Not very much	24	43	42	22	20	15
Not at all	7	4	4	-	1	4
The increased availability of health insurance provided by employers						
Very much	26	38	34	46	55	19
Somewhat	44	50	49	48	38	46
Not very much	19	11	14	4	6	31
Not at all	6	1	3	2	-	-

*Less than 0.5%.

Underlying Causes of the Increase in Health Care Spending

It is widely recognized that as long as third-party payers assume all (or most) of the cost of health care, providers and patients have no incentive to pare down services or usage.

Four statements describing possible underlying causes of the increase in health care spending were presented to the respondents — two statements reflected on patient behavior and two reflected on provider behavior.

In all of the groups except union leaders, 78% or more of the respondents agreed with the first two statements — "if most patients don't have to pay for hospital care, they will want the best care available, no matter how expensive it is" and "people would use fewer health care services if they personally had to pay a greater share of the cost" (Table 2-3).

Agreement with the statement, "one of the problems with health care is that there is no real competition to keep prices down," is expressed by more than 75% of the American public, insurance executives, union leaders and corporate benefits officers, by 55% of the hospital administrators, but by only 27% of the physician leaders.

While more than 60% of all the other groups agree with the statement "if doctors and hospitals know that insurance and not the patient is paying, they will provide care without regard to cost," only 53% of the physician leaders agree with it.

Table 2-3

UNDERLYING CAUSES OF THE INCREASE IN HEALTH CARE SPENDING

Q. Now, I will read you some statements about some causes for the increase in health care spending and some possible solutions. Please tell me, for each one, if you agree with it or disagree with it.

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
If most patients don't have to pay for hospital care, they will want the best care available, no matter how expensive it is						
Agree	84	92	85	90	93	81
Disagree	15	8	15	10	6	15
People would use fewer health care services if they personally had to pay a greater share of the cost						
Agree	78	96	92	94	96	69
Disagree	20	3	6	6	4	27
One of the problems with health care is that there is no real competition to keep prices down						
Agree	76	27	55	80	89	81
Disagree	21	73	42	20	10	19
If doctors and hospitals know that insurance and not the patient is paying, they will provide care without regard to cost						
Agree	74	53	63	78	86	69
Disagree	24	46	36	22	13	27

Reasons for the Increased Concentration of Health Care Spending

It is generally recognized that the majority of health care expenditures are incurred by a fairly small minority of the population.

The professional groups were asked to estimate what percentage of all health care costs were incurred by the highest-spending 10% of the population. A breakdown of these estimates is presented in Table 2-4. The median estimates range from 36% by union leaders to 59% by corporate benefits officers.

Observation:

*Although at the writing of this report hard evidence is not available on the correct answer to the above question, experts estimate that this percentage is in excess of 60%.*¹

The reasons considered to contribute most to the increased concentration are listed in Table 2-5. The two reasons cited most frequently by physician leaders and hospital administrators are: first, "the aging of the population," and second, "the use of expensive procedures to save or prolong life." Union leaders cite the above two reasons equally often (23% each), and cite "overuse and abuse of health care services by a few people" a little less frequently (19%). Insurance executives cite "overuse and abuse of health care services by a few people" substantially more frequently (28%) than they cite any other reason (18% or less).

While 22% of corporate benefits officers view "use of expensive procedures" as contributing most to the increased concentration of health care spending, they do not appear to agree on any other single reason.

¹ A study of the Federal Employee Benefit Program conducted by the Congressional Budget Office in 1978 reports that 10% of the families covered accounted for 67% of the total expenditures. The Health Care Financing Administration reports that in 1978, 8.8% of the elderly enrolled in Medicare accounted for 70.3% of the expenditures.

Table 2-4

**ESTIMATES OF THE PERCENTAGE OF HEALTH CARE COSTS INCURRED
BY THE HIGHEST-SPENDING 10% OF THE POPULATION**

Base: Professional groups only

Q. It is clear that some people incur more health care costs than others. What percentage of all health care costs do you think is incurred by the 10% of the population who are the biggest consumers and who incur the highest costs?

	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	100	100	50	250	26
	%	%	%	%	%
Less than 30%	11	8	4	8	19
30% to 39%	15	14	22	13	15
40% to 49%	21	23	18	8	8
50% to 59%	17	13	8	12	-
60% to 75%	20	21	30	23	12
More than 75%	6	7	14	17	4
Not sure	9	14	4	18	39
Median	49%	49%	55%	59%	36%

Table 2-5

REASONS FOR THE INCREASED CONCENTRATION OF HEALTH CARE SPENDING

Base: Professional groups only

Q. The evidence is that the concentration of health care costs is growing. In other words, the 10% who incur the highest costs are consuming a higher and higher proportion of all costs. Which one of the following do you think contributes most to the increased concentration of health care spending?

	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	100	100	50	250	26
	%	%	%	%	%
Aging of the population	31	30	18	13	23
Use of expensive procedures to save or prolong life	23	22	18	22	23
Overuse and abuse of health care services by a few people	14	6	28	17	19
New medical technology	10	14	12	16	12
Unhealthy lifestyles	10	14	16	14	4
More insurance coverage	7	10	2	16	8
None of these (vol.)	-	1	4	*	8
Not sure	5	3	2	1	4

*Less than 0.5%.

CHAPTER 3: REACTIONS TO PROPOSED COST- CONTAINMENT CHANGES IN HEALTH CARE SERVICES AND COVERAGE

Introduction

The American public rated nineteen proposed cost-containment policies and programs on how effective and how acceptable they felt each would be from their personal perspective. The professional groups similarly rated the effectiveness of each of these nineteen programs and proposals as well as five additional ones. They also rated the twenty-four policies and programs on their acceptability. Tables 3-1 and 3-2 present these data.

Each proposal will be discussed in terms of its effectiveness and acceptability, as it was judged by each sample interviewed. For the purposes of this discussion, the two positive responses, "very effective" and "somewhat effective" will be collapsed into one, as will the responses "very acceptable" and "somewhat acceptable." The reader is encouraged to examine the detailed breakdown of responses presented in the tables.

General Findings

The conventional wisdom that the American public would resist major changes in the health care field appears to be unfounded. The findings reported in this chapter suggest that in making these changes, employers and the government would be likely to meet much less resistance from the public than generally is believed.

The major finding is the remarkable acceptance by the public of a broad range of policies, including those that would increase out-of-pocket costs and minimally curtail freedom of choice among health care options.

Other general findings of note are the willingness of hospital administrators to accept policies that would result in a reduction in hospital use and income, and the contrasting unwillingness of physician leaders to accept changes, particularly those likely to adversely affect the current financial incentives for the profession.

Detailed Findings

For the purpose of discussing the detailed findings, the proposed cost-containment policies and programs are grouped together on the basis of common underlying themes.

• Proposed changes in health care coverage designed to reduce nonessential utilization by shifting more out-of-pocket cost to the American public

The American public is surprisingly willing to recognize the effectiveness of most of these changes, and to accept many of them.

Specifically, about two-thirds or more of the American public consider changes that would require employees to pay a part of their health insurance premiums, that would increase the deductible, and that would prevent the dual-filing of claims for the same medical services to be effective cost-containment strategies. Although not overly enthusiastic about these changes, significant majorities (58% to 67%) of the public are willing to accept them.

On the other hand, although about two-thirds of the public recognize the proposal to increase copayments as an effective strategy, the sample is evenly split on its acceptability.

While the opinions of union leaders generally parallel those of the American public on the deductibles, copayments, and dual-filing of claims issues, this group is evenly split on the acceptability of the proposal to require employees to pay part of the insurance premiums. Majorities of respondents in all the other professional groups endorse these changes in terms of both effectiveness and acceptability.

The proposal to tax a portion of the employer-paid insurance premium is generally considered ineffective and unacceptable by more than two-thirds of the insurance executives, corporate benefits officers, and union leaders, and by about half of the hospital administrators and the American public. Relative to the other groups, physician leaders are most likely (62%) to find this suggestion acceptable.

Observation

The finding that most of the respondents find the tax on insurance premiums an ineffective cost control strategy is clearly logical in view of the fact that this policy, unlike the others, does not provide any incentive for lower utilization of nonessential health care services.

- **Proposed changes in insurance plans that provide a lower-cost option to patients, usually with some built-in constraints, such as less freedom of choice regarding health care providers and procedures**

Majorities of the American public recognize that all these proposed changes are likely to be effective in containing health care costs and the public is generally (though not overwhelmingly) willing to accept these measures. Physician leaders are notably resistant to recognizing them as either effective or acceptable cost-containment strategies. It should be noted that many of these proposals imply competition between health care providers and involve a potential loss of income.

Requiring the patient to get a second opinion in the case of non-emergency surgery is seen as an effective cost-containment proposal as well as an acceptable one by large majorities (70% to 93%) of the American public and of all the professional groups *except* physician leaders. Although 63% of the physician leaders find this proposal acceptable, a minority (32%) consider it effective.

Prepaid health care plans (e.g., health maintenance organizations) are most likely to be viewed as effective by union leaders (73%); they are seen as somewhat less effective by the public, corporate and insurance executives (59% to 68%), and they are least likely to be seen as effective by physician leaders (34%) and hospital administrators (49%). The acceptability of prepaid plans is similarly lowest among physician leaders (37%) and highest among union leaders (77%).

Although precertification (prior payment approval) of nonemergency hospitalization by insurance companies is recognized as an effective cost-containment strategy by significant majorities (58% to 89%) in all groups interviewed, it is generally considered acceptable by fewer people in each group, particularly among physician leaders (34%) and hospital administrators (47%). A sizable minority of the American public (41%) consider this proposal unacceptable.

At least 70% of the American public feel that changes that require the use of a designated primary care physician, that include only health

care providers with lower prices in an insurance plan, or that provide incentives such as lower out-of-pocket costs to patients who use designated providers ("preferred provider") are effective cost-containment strategies. However, acceptability to the public of these proposals is not as high (69%, 62%, and 61%, respectively). Generally, the primary care physician and preferred provider proposals are viewed as more effective and acceptable by all professional groups than are restricting coverage to providers with lower prices. Physician leaders stand out in that they are more likely than all the other professional groups to find all of these proposals unacceptable.

A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians is considered an effective cost-containment strategy by majorities of the American public (64% to 93%) and all professional groups except the physician leaders (30%). Sizeable minorities of the American public (35%) and hospital administrators (40%) find this proposal unacceptable, while the majority of physician leaders (75%) say it is unacceptable to them.

- **Proposals that suggest providing incentives for health maintenance and preventive care**

Majorities of the American public and in all the professional groups (76% to 82%) agree that insurance plans that offer incentives to people who practice health and safety procedures are likely to be effective in containing health care costs. Even greater majorities (79% to 97%) find this proposal acceptable. This is not surprising when one considers the fact that this is one of the few proposals that does not imply reduced income for providers or increased cost — financial or otherwise — to consumers.

Surprisingly, all professional groups except union leaders view the proposal for "insurance plans that give refunds to be shared among all employees when their total health care expenditures fall below target" as acceptable and effective. While 62% of the union leaders find this proposal acceptable, they are about evenly split with respect to its expected effectiveness in containing costs.

- **Proposals that are aimed at keeping hospitalization to a minimum by offering other treatment options**

Vast majorities in all groups (81% to 99%), including hospital administrators, believe that having tests and minor surgery done in clinics and doctors' offices rather than in hospitals, or treating the chronically ill at home instead of in hospitals and nursing homes are effective cost-containment strategies. Similarly, overwhelming majorities of respondents in all groups consider these proposals acceptable.

Particularly impressive is the open-mindedness displayed by the hospital administrators, whose institutions would clearly be affected by these proposals.

- **Proposals to place constraints on prices of health care services and equipment purchase and use**

While the American public and most of the professional groups recognize the efficacy of constraints on prices, equipment purchase, and utilization and consider these constraints acceptable, physician leaders are generally unaccepting of these constraints. By contrast, again, the majority of hospital administrators are willing to accept these constraints.

While more than three-quarters of the American public believe that diagnosis-related fixed prices would be an effective as well as acceptable means of cost containment, only 51% of the physician leaders view this proposal as effective, and still fewer (32%) consider it acceptable. The physician leaders' views also contrast remarkably with those of hospital administrators, majorities of whom (84%) recognize the effectiveness of this proposal and are willing to accept it (71%). The other professional groups are largely supportive (more than 70%) of this proposal.

Majorities in all of the other professional groups except union leaders find the idea of government price controls of doctors' and hospital fees generally both unacceptable and ineffective.

With regard to the proposal to curb unrestrained purchase of expensive equipment at hospitals, there is clear recognition of its merit as a cost-containment measure by the American public and by all of the professional groups. Physician leaders, however, are least likely (58%) to recognize that reducing the duplication of expensive equipment and specialists at hospitals close to each other would be an effective cost-containment strategy. Astonishingly, this proposal is considered acceptable by fewer physician leaders (51%) than hospital administrators (73%).

Limiting the use of expensive medical technology for patients with virtually no hope of recovery is a proposal that, although generally recognized as an effective cost-containment strategy by all groups, is considered acceptable by less than half of the respondents in all groups except physician leaders, 59% of whom consider it acceptable.

Business coalitions formed to reduce health care costs are viewed as both effective and acceptable by large majorities of all professional groups. Utilization reviews by third-party payers are viewed as effective by sizable majorities in all groups, and they are more acceptable to insurance executives (96%), corporate benefits officers (93%), and union leaders (80%) than they are to hospital administrators (66%) and physician leaders (52%). It appears that the physician leaders generally are unwilling to accept any price constraints on or review of their practice of medicine.

- **Proposed changes in malpractice and anti-trust laws**

The physician leaders overwhelmingly support the changing of laws that encourage doctors to practice defensive medicine to protect themselves from malpractice suits. This proposal is also viewed as both effective and acceptable by all of the professional groups.

On the other hand, the proposal to change antitrust laws to allow third-party payers to join together and

negotiate costs with health care providers meets with a mixed reaction. Large majorities among union leaders, corporate benefits officers, and insurance executives (88% to 96%) consider this proposal both effective and acceptable. Smaller majorities of physician leaders (69%) and hospital administrators (77%) consider it effective, but their views on its acceptability contrast sharply. Whereas only 47% of physician leaders find it acceptable, 69% of hospital administrators do so.

Table 3-1

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

Q. Do you think it will be very effective, somewhat effective, not very effective, or not at all effective in *controlling costs or discouraging use of nonessential services?*

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
In the case of non-emergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary						
Very effective	58	5	29	32	46	54
Somewhat effective	27	27	42	38	44	19
Not very/not at all effective	14	68	28	28	10	27
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals						
Very effective	57	56	50	62	77	65
Somewhat effective	30	38	37	34	22	27
Not very/not at all effective	12	6	11	4	1	8
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes						
Very effective	49	50	58	56	62	46
Somewhat effective	32	39	34	38	34	46
Not very/not at all effective	16	10	7	6	4	4
Insurance plans that offer incentives to people who practice health and safety procedures — such as non-smokers, seatbelt users, or those who are not overweight						
Very effective	44	30	30	34	25	35
Somewhat effective	35	52	50	42	53	42
Not very/not at all effective	19	18	19	22	20	16

Continued

Table 3-1 (Continued)

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Preventing people in families where more than one person has employer-provided health insurance from filing more than one insurance claim for the same medical services						
Very effective	42	30	40	54	52	46
Somewhat effective	30	38	41	34	31	23
Not very/not at all effective	24	29	14	12	14	23
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed						
Very effective	38	8	32	28	27	35
Somewhat effective	40	43	52	52	54	38
Not very/not at all effective	18	45	13	20	16	20
Government price controls of doctors' and hospital fees						
Very effective	38	13	18	14	15	58
Somewhat effective	29	33	26	18	28	19
Not very/not at all effective	29	52	52	68	55	20
A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians						
Very effective	35	3	25	22	27	35
Somewhat effective	38	27	39	46	56	58
Not very/not at all effective	25	67	35	30	17	8
A system that discourages a hospital from having expensive equipment and specialists, if they are available at another hospital nearby						
Very effective	35	15	32	52	51	46
Somewhat effective	32	43	47	36	38	27
Not very/not at all effective	31	41	20	10	11	23

Continued

Table 3-1 (Continued)

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Increasing the deductible — the costs that a patient must pay before the insurance plan starts to cover medical expenses — so that people become more cost-conscious when seeking medical services						
Very effective	33	51	37	52	56	39
Somewhat effective	36	37	43	42	40	35
Not very/not at all effective	28	10	19	4	4	24
Limiting the use of ex- pensive medical technology for patients who have virtually no hope of recovery						
Very effective	33	38	35	52	23	27
Somewhat effective	30	48	42	48	46	35
Not very/not at all effective	31	11	19	18	28	27
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient						
Very effective	32	11	33	44	36	36
Somewhat effective	44	53	50	44	53	46
Not very/not at all effective	21	35	15	10	11	15
Requiring employees to pay a part of their health insurance premiums						
Very effective	31	35	33	34	38	27
Somewhat effective	36	49	41	38	41	23
Not very/not at all effective	30	15	25	28	21	46

Continued

Table 3-1 (Continued)

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses						
Very effective	29	45	36	50	58	35
Somewhat effective	37	42	45	42	38	31
Not very/not at all effective	31	11	17	8	4	27
A system in which the patient has to obtain from the insurance company payment approval for specific expenses and length of hospitalization prior to nonemergency hospitalization						
Very effective	28	15	18	50	51	38
Somewhat effective	39	43	46	34	38	23
Not very/not at all effective	30	41	34	14	11	34
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services						
Very effective	27	5	16	32	22	35
Somewhat effective	32	29	33	26	46	38
Not very/not at all effective	37	64	49	42	31	27
Including only hospitals and doctors with lower prices in a health insurance plan, and excluding those that are more expensive						
Very effective	24	8	15	28	26	31
Somewhat effective	48	43	46	52	49	46
Not very/not at all effective	24	47	38	20	22	23

Continued

Table 3-1 (Continued)

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list						
Very effective	24	9	25	44	28	27
Somewhat effective	46	49	53	48	57	50
Not very/not at all effective	26	39	22	8	13	23
Requiring employees whose employers pay large health insurance premiums for them to pay taxes on the portion of the premium that exceeds \$840 for the individual and \$2,100 for the family						
Very effective	18	15	16	2	4	19
Somewhat effective	28	41	29	20	22	12
Not very/not at all effective	47	40	50	78	72	66
Changing laws that seem to encourage doctors to order tests and procedures just to protect themselves from malpractice suits						
Very effective	x	40	35	38	34	31
Somewhat effective	x	45	43	38	43	46
Not very/not at all effective	x	14	18	24	22	20
Insurance plans that give refunds to be shared among all employees when their total health care expenditures fall below target						
Very effective	x	25	26	30	22	19
Somewhat effective	x	55	49	44	52	35
Not very/not at all effective	x	19	22	26	25	46

Continued

Table 3-1 (Continued)

ANTICIPATED EFFECTIVENESS OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
Changing antitrust laws to allow third-party payers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders						
Very effective	x	12	29	50	47	46
Somewhat effective	x	57	48	44	42	50
Not very/not at all effective	x	29	19	6	9	
Businesses and employers in particular cities or areas working together in health care coalitions to reduce costs						
Very effective	x	21	28	40	45	46
Somewhat effective	x	57	59	50	50	50
Not very/not at all effective	x	20	12	8	5	4
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures						
Very effective	x	18	25	42	44	27
Somewhat effective	x	44	49	40	49	54
Not very/not at all effective	x	37	25	14	7	8

x = Not asked

Table 3-2

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

Q Would it be very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable to you personally/as a professional in this field?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
In the case of non-emergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary						
Very acceptable	64	27	46	54	64	58
Somewhat acceptable	24	36	38	38	29	23
Not very/not at all acceptable	10	37	15	8	6	19
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals						
Very acceptable	56	67	55	70	83	58
Somewhat acceptable	27	32	29	26	14	23
Not very/not at all acceptable	16	1	13	4	2	20
Insurance plans that offer incentives to people who practice health and safety procedures — such as non-smokers, seatbelt users, or those who are not overweight						
Very acceptable	52	75	63	56	45	46
Somewhat acceptable	28	22	29	34	34	38
Not very/not at all acceptable	18	2	7	8	20	12
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes						
Very acceptable	46	66	60	62	57	46
Somewhat acceptable	32	25	31	34	36	38
Not very/not at all acceptable	20	7	8	4	8	12

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Preventing people in families where more than one person has employer-provided health insurance from filing more than one insurance claim for the same medical services						
Very acceptable	40	59	65	60	49	66
Somewhat acceptable	27	21	15	22	22	15
Not very/not at all acceptable	29	19	16	18	26	12
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed						
Very acceptable	37	6	27	32	26	38
Somewhat acceptable	39	26	44	52	50	35
Not very/not at all acceptable	21	67	27	16	23	19
Government price controls of doctors' and hospital fees						
Very acceptable	34	1	10	6	13	50
Somewhat acceptable	27	6	11	14	14	15
Not very/not at all acceptable	36	90	74	78	70	27
A system that discourages a hospital from having expensive equipment and specialists, if they are available at another hospital nearby						
Very acceptable	32	18	43	58	54	62
Somewhat acceptable	30	33	30	26	30	12
Not very/not at all acceptable	36	47	25	16	15	24
A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians						
Very acceptable	29	4	24	30	28	31
Somewhat acceptable	34	20	35	48	45	42
Not very/not at all acceptable	35	75	40	20	26	23

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Requiring employees to pay a part of their health insurance premiums						
Very acceptable	29	54	45	42	45	27
Somewhat acceptable	36	35	36	36	32	19
Not very/not at all acceptable	32	10	18	22	22	50
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services						
Very acceptable	29	6	23	32	25	35
Somewhat acceptable	32	31	43	38	42	42
Not very/not at all acceptable	36	61	33	30	33	23
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient						
Very acceptable	29	11	40	46	32	31
Somewhat acceptable	40	37	40	38	51	38
Not very/not at all acceptable	29	52	19	14	17	27
Limiting the use of expensive medical technology for patients who have virtually no hope of recovery						
Very acceptable	25	24	20	8	9	12
Somewhat acceptable	24	35	28	20	27	27
Not very/not at all acceptable	46	38	49	72	61	50

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Increasing the deductible — the costs that a patient must pay before the insurance plan starts to cover medical expenses — so that people become more cost-conscious when seeking medical services						
Very acceptable	24	58	41	46	56	27
Somewhat acceptable	34	31	38	42	34	38
Not very/not at all acceptable	39	10	20	12	10	35
Including only hospitals and doctors with lower prices in a health insurance plan, and excluding those that are more expensive						
Very acceptable	22	7	11	18	12	19
Somewhat acceptable	40	24	34	32	30	46
Not very/not at all acceptable	34	68	53	48	56	35
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list						
Very acceptable	22	6	31	44	24	19
Somewhat acceptable	39	35	37	42	45	58
Not very/not at all acceptable	36	58	32	14	31	20
A system in which the patient has to obtain from the insurance company payment approval for specific expenses and length of hospitalization prior to nonemergency hospitalization						
Very acceptable	22	7	13	34	38	23
Somewhat acceptable	35	27	34	36	38	38
Not very/not at all acceptable	41	66	51	28	23	38

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses						
Very acceptable	19	48	33	42	49	19
Somewhat acceptable	33	34	43	40	36	27
Not very/not at all acceptable	46	17	22	18	14	46
Requiring employees whose employers pay large health insurance premiums for them to pay taxes on the portion of the premium that exceeds \$840 for the individual and \$2,100 for the family						
Very acceptable	14	25	20		4	12
Somewhat acceptable	25	37	31	18	16	8
Not very/not at all acceptable	56	36	43	82	78	77
Businesses and employers in particular cities or areas working together in health care coalitions to reduce costs						
Very acceptable	x	37	43	74	69	65
Somewhat acceptable	x	48	44	24	30	23
Not very/not at all acceptable	x	15	12	2	1	12
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures						
Very acceptable	x	15	35	60	57	42
Somewhat acceptable	x	37	31	36	36	38
Not very/not at all acceptable	x	47	33	2	6	8

Continued

Table 3-2 (Continued)

ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
Changing antitrust laws to allow third-party payers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders						
Very acceptable	x	13	30	58	56	62
Somewhat acceptable	x	34	39	30	32	27
Not very/not at all acceptable	x	52	27	12	9	8
Changing laws that seem to encourage doctors to order tests and procedures just to protect themselves from malpractice suits						
Very acceptable	x	61	49	52	41	35
Somewhat acceptable	x	25	28	24	32	42
Not very/not at all acceptable	x	12	20	24	26	20
Insurance plans that give refunds to be shared among all employees when their total health care expen- ditures fall below target						
Very acceptable	x	49	47	40	36	27
Somewhat acceptable	x	40	41	44	43	35
Not very/not at all acceptable	x	10	10	16	21	39

x = Not asked

Views of Those Corporate Benefits Officers Whose Companies Have Had Experience With Specific Cost-Containment Programs

Experience with a cost-containment program does not necessarily increase the program's likelihood of being endorsed as effective. However, some programs are clearly working well, because those benefits officers who have had experience with certain programs give those programs more favorable ratings than do those who have had no experience.

Table 3-3 presents the data on the anticipated effectiveness of each of selected cost-containment programs as judged by corporate benefits officers whose companies have had experience with the program compared with those whose companies have not had experience with the program. (Only those programs with which at least 20% of the respondents have had experience were analyzed in this manner.)

The data reveal that experience with the following programs generally correlates positively with views that the programs are "very effective" in cost containment:

- "Requiring employees to pay a part of their health insurance premiums";
- "Preventing people in families where more than one person has employer-provided health insurance from filing more than one insurance claim for the same medical services";
- "Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures";
- "Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes"; and
- "A system that encourages the use of nurse practitioners, midwives, and physician's assistants rather than physicians."

Table 3-3

**EFFECTIVENESS OF COST-CONTAINMENT PROGRAMS AS JUDGED BY
BENEFITS OFFICERS AT COMPANIES WITH EXPERIENCE WITH EACH PROGRAM¹**

Base: Corporate benefits officers

Q. Do you think it will be very effective, somewhat effective, not very effective, or not at all effective in *controlling costs or discouraging use of nonessential services?*

	Total	Has Experience With Program	No Experience With Program
No. of Respondents	250	Varies ²	Varies ³
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals			
Very effective	77	79	75
Somewhat effective	22	20	23
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes			
Very effective	62	72	55
Somewhat effective	34	25	40
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses			
Very effective	58	62	54
Somewhat effective	38	35	41
Increasing the deductible — the costs that a patient must pay before the insurance plan starts to cover medical expenses — so that people become more cost-conscious when seeking medical services			
Very effective	56	59	52
Somewhat effective	40	40	40
Preventing people in families where more than one person has employer-provided health insurance from filing more than one insurance claim for the same medical services			
Very effective	52	71	36
Somewhat effective	31	22	38
In the case of nonemergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary			
Very effective	46	51	42
Somewhat effective	44	42	45

Continued

Table 3-3 (Continued)

EFFECTIVENESS OF COST-CONTAINMENT PROGRAMS AS JUDGED BY
BENEFITS OFFICERS AT COMPANIES WITH EXPERIENCE WITH EACH PROGRAM¹

Base: Corporate benefits officers

	Total	Has Experience With Program	No Experience With Program
No. of Respondents	250	Varies ²	Varies ³
The health care coalitions of businesses and employers in particular cities or areas where they work together to reduce costs			
Very effective	45	42	47
Somewhat effective	50	51	50
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures			
Very effective	44	51	36
Somewhat effective	49	44	53
Requiring employees to pay a part of their health insurance premiums			
Very effective	38	45	24
Somewhat effective	41	38	46
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient			
Very effective	36	40	33
Somewhat effective	53	48	56
A system that encourages the use of nurse practitioners, midwives, and physician's assistants rather than physicians			
Very effective	27	38	24
Somewhat effective	56	58	55
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services			
Very effective	22	21	23
Somewhat effective	46	58	39

¹ Only those programs with which at least 20% of the respondents' companies have experience are reported in this table (see Table 4-1).

² The bases for those corporate benefits officers who have had experience vary — with the first program listed having the highest base (162) and the last one having the lowest (53).

³ The bases for those corporate benefits officers who have had no experience also vary — with the first program listed having the lowest base and the last one having the highest.

Attitudes Toward Proposed Trade-offs in Health Care Coverage

The American public is not entirely unanimous about the fairness of the proposed changes in health insurance plans that involve a trade-off between better coverage for some health care services and higher cost to the patient for others.

Sixty-seven percent consider as fair and reasonable the proposal for better insurance coverage for tests conducted without hospitalization than for tests that involve overnight hospitalization; however, only 51% consider a similar proposal regarding surgery to be fair and reasonable (Table 3-4). Similarly, more union leaders (92%) consider the former fair and reasonable than view the latter as such (50%). More than 75% of the respondents in the other professional groups — physician leaders, hospital administrators, insurance executives, and corporate benefits officers — consider both proposed trade-offs fair and reasonable.

The proposal to require higher deductibles and copayments while adding dental and vision benefits to a health care plan is considered fair and reasonable by 65% of the American public and 58% of union leaders. Compared with the other four proposals, this one is considered fair and reasonable by the lowest number of respondents in the other professional groups, particularly among physician leaders and hospital administrators.

A trade-off requiring higher deductibles and initial cost-sharing for better coverage of longer-term treatment is considered fair and reasonable by more than 80% of all professional groups except union leaders, only 50% of whom consider it so. A majority of the American public (61%) consider this proposal fair.

The American public, like union leaders, displays a split in its opinion about the fairness of paying a larger share of the cost of emergency room care while getting better coverage for treatment at doctors' offices. Clear majorities in the other professional groups consider this trade-off to be fair and reasonable.

Table 3-4

TRADE-OFFS IN HEALTH CARE COVERAGE CONSIDERED FAIR AND REASONABLE

Q. I will read you some proposed changes in health insurance plans that involve a trade-off between better coverage for some health care services and higher cost to the patient for others. For each one, please tell me if you think the trade-off is fair and reasonable.

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Providing better coverage for tests conducted without hospitalization than for tests involving overnight hospitalization						
Yes, is fair and reasonable	67	87	77	92	94	92
No, isn't fair and reasonable	28	12	21	8	6	8
Requiring higher deductibles and copayments but adding dental and vision benefits in the health care plan						
Yes, is fair and reasonable	65	55	60	74	73	56
No, isn't fair and reasonable	30	43	36	26	22	35
Requiring higher deductibles and copayments for the initial cost of health care, but with better coverage for the cost of longer-term treatment						
Yes, is fair and reasonable	61	96	84	86	92	50
No, isn't fair and reasonable	34	2	14	12	6	42
Requiring a patient to pay a larger share of the cost of care obtained at hospital emergency rooms, but with better coverage for treatment at the doctor's office						
Yes, is fair and reasonable	52	83	72	84	79	46
No, isn't fair and reasonable	44	14	26	16	20	42
Requiring patients to pay a larger share of the cost of overnight hospital stays, but providing better coverage for surgery that does not involve hospitalization						
Yes, is fair and reasonable	51	80	76	84	88	50
No, isn't fair and reasonable	44	17	23	16	11	42

CHAPTER 4: EXPERIENCE AND POLICIES OF CORPORATIONS AND UNIONS REGARDING HEALTH CARE PROGRAMS

Experience With Specific Cost-Containment Programs

Corporate benefits officers and union leaders were asked to indicate whether or not they had had any experience with each of several cost-containment policies and programs discussed in Chapter 3. Table 4-1 summarizes their responses.

Majorities of corporations have had experience with programs that require greater cost-sharing (premiums, deductibles, copayments) from the

patient, with those that discourage the use of hospitals for tests and minor surgery, and with business coalitions and prepaid (HMO-type) health care programs.

The majority of unions, on the other hand, have had experience with prepaid health care, discouraging the filing of dual claims for the same services, and requiring second opinions on nonemergency surgery. Only about one-third of unions have had experience with increased direct cost-sharing by their members.

Table 4-1

ORGANIZATIONS' EXPERIENCE WITH COST-CONTAINMENT PROGRAMS

Base: Corporate benefits officers and union leaders only

Q. I am going to read you a list of some of the programs and policies again. This time, please tell me if your organization has had any experience with each one, or not.

No. of Respondents	Corporate Benefits Officers 250	Union Leaders 26
Requiring employees to pay a part of their health insurance premiums	65	38
The health care coalitions of businesses and employers in particular cities or areas where they work together to reduce costs	64	27
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals	63	42
Increasing the deductible — the costs that a patient must pay before the insurance plan starts to cover medical expenses — so that people become more cost-conscious when seeking medical services	61	38
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services	58	62

Table 4-1 (Continued)

ORGANIZATIONS' EXPERIENCE WITH COST CONTAINMENT PROGRAMS

Base: Corporate benefits officers and union leaders only

No. of Respondents	Corporate Benefits Officers	Union Leaders
Requiring patients to pay a <i>greater</i> part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses	54	31
In the case of nonemergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary	51	69
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures	41	35
Preventing people in families where more than one person has employer-provided health insurance from filing more than one insurance claim for the same medical services	41	65
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes	39	35
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient	34	38
A system that encourages the use of nurse practitioners, midwives, and physician's assistants rather than physicians	21	35
A system in which the patient has to obtain from the insurance company payment approval for specific expenses and length of hospitalization <i>prior</i> to nonemergency hospitalization	14	27
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list	11	23
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed	10	42
Insurance plans that offer incentives to people who practice health and safety procedures — such as nonsmokers, seatbelt users, or those who are not overweight	8	8
Including only hospitals and doctors with lower prices in a health insurance plan, and <i>excluding</i> those that are more expensive	4	15
Insurance plans that give refunds to be shared among all employees when their total health care expenditures fall below target	4	8

Review of Health Care Benefits

While 92% of the corporate benefits officers report that their organizations reviewed their health care benefits during the past year with the objective of reducing costs, only 69% of union leaders report that their organization did so (Table 4-2).

Table 4-2

MOST RECENT REVIEW OF HEALTH CARE BENEFITS

Base: Corporate benefits officers and union leaders

Q. When was the last time your organization reviewed its health care benefits with the objective of reducing costs? Was it within the past year, one to two years ago, or more than two years ago?

	Corporate Benefits Officers	Union Leaders
No. of Respondents	250	26
Within the past year	92	69
1 to 2 years ago	5	12
More than 2 years ago	3	15
Not sure	0	4

*Less than 0.5%

Cost-Sharing With Employees or Union Members

Table 4-3 presents data on the relative number of corporations and unions that require their employees or members to share the cost of health care coverage and services. Clearly, corporations are more demanding of their employees on this matter than are unions.

Table 4-3

COST-SHARING WITH EMPLOYEES OR UNION MEMBERS

Base: Corporate benefits officers and union leaders

Q. Do you require your (employees/union members) to pay (READ EACH ITEM)?

	Corporate Benefits Officers	Union Leaders
No. of Respondents	250	26
A part of the premium		
Yes, require	53	15
No, don't require	44	73
A deductible		
Yes, require	95	69
No, don't require	4	27
Copayments		
Yes, require	88	35
No, don't require	9	54

Administration of Claims Payments

While 24% of the corporations use a third-party administrator for claims payments, only 12% of the unions do so. Corporations primarily rely on their insurance carrier to handle claims payments, while unions administer them within their own organization (Table 4-4).

Of the 60 corporate benefits officers whose companies use third-party administrators, 52% believe that the administrators are better able to control costs than they themselves or their insurance carrier are (Table 4-5). The reasons given for this are as expected: "They have more expertise and experience...they are more objective and impartial...they save us money...they have better access to insurance information...we don't have the personnel resources for it."

Table 4-4

ADMINISTRATION OF CLAIMS PAYMENTS

Base: Corporate benefits officers and union leaders

Q. Who is responsible for the administration of claims payments for your organization's health care plan? Is it a person or department within your organization, your insurance carrier, a third-party administrator, or someone else?

	Corporate Benefits Officers	Union Leaders
No. of Respondents	250	26
A person or department within your organization	22	46
Your insurance carrier	53	38
A third-party administrator	24	12

Table 4-5

OPINIONS ON THE ABILITY OF THIRD-PARTY ADMINISTRATORS TO CONTROL COSTS

Base: Corporate benefits officers and union leaders

Q. In your view, are third-party administrators better able to control an organization's health care costs than you yourself or insurance companies can?

	No. of Respondents	Yes, Are Better Able	No, Aren't Better Able
Corporate Benefits Officers			
Use third-party administrators	60	52	43
Do not use third-party administrators	188	17	67
Union Leaders			
Use third-party administrators	3	x	x
Do not use third-party administrators	22	23	73

x = The base for this group is too small for meaningful analysis through a computation of percentages.

Self-Funded and Cafeteria-Style Benefits

Self-funded insurance plans and cafeteria-style benefit programs are two means that corporations can use to control the administrative costs of providing health care benefits to their employees.

While 78% of corporations surveyed have a self-funded insurance plan (Table 4-6), and 70% of them have had that plan for more than three years, cafeteria-style benefits are still very rare. Only 7% of the corporate benefits officers report that their companies offer them (Table 4-7).

Of the 56 companies that have had a self-funded plan for three years or less, 75% report that it has resulted in more overall cost savings, in terms of real dollars, than the plan they had before. Furthermore, 82% of these companies have become more conscious of the amount paid out under this type of health plan.

When asked whether they think cafeteria-style benefits are effective in controlling health care costs, 58% of corporate benefits officers answer in the affirmative; 31% think they are not effective (Table 4-8). This suggests that perhaps more companies may be willing to try this approach. (Although not reported in tabular form, the survey reveals that 68% of the companies who do not have cafeteria-style benefits have considered offering them.)

Table 4-6

SELF-FUNDED INSURANCE PLANS

Base: Corporate benefits officers

Q. Does your company have a self-funded insurance plan?

No. of Respondents	Corporate Benefits Officers
	250
Yes, has plan	78
No, doesn't have plan	18
Not sure	3

Table 4-7

CAFETERIA-STYLE BENEFITS

Base: Corporate benefits officers

Q. Does your company offer its employees cafeteria-style benefits in which your company allows employees to choose among all benefits?

	Corporate Benefits Officers
No. of Respondents	250
Yes, offers	7
No, doesn't offer	93
Not sure	*

*Less than 0.5%.

Table 4-8

**PERCEIVED EFFECTIVENESS OF
CAFETERIA-STYLE BENEFITS IN
CONTROLLING HEALTH CARE COSTS**

Base: Corporate benefits officers

Q. Do you think cafeteria-style benefits are very effective, somewhat effective, not very effective, or not at all effective in controlling the cost of health care?

	Corporate Benefits Officers
No. of Respondents	250
Very effective	7
Somewhat effective	51
Not very effective	23
Not at all effective	8
Not sure	10

CHAPTER 5: OPINIONS ON COST-SHIFTING AND HEALTH CARE COVERAGE FOR THE UNEMPLOYED

Shifting Costs From Medicare and Medicaid Patients to Other Patients

Majorities of respondents in all groups disapprove of doctors and hospitals charging higher fees for patients who pay their own bills or are covered by private insurance than for Medicare and Medicaid patients (Table 5-1).

Surprisingly, 22% of the American public approve of this 'cost-shifting.' What is even more surprising is that these 22% are not primarily Medicare and Medicaid recipients (Table 5-2). The only subgroup of the American public that disapproves of cost-shifting in a relatively larger proportion than the others is the subgroup with no insurance coverage.

Table 5-1

ATTITUDES TOWARD MEDICARE AND MEDICAID "COST-SHIFTING": THE PUBLIC AND PROFESSIONALS COMPARED

Q. Current and proposed government regulations limit the amount the government will pay hospitals and doctors for Medicare and Medicaid patients. Some doctors and hospitals, therefore, are paid less for Medicare and Medicaid patients, and charge higher fees for patients who pay their own bills or are covered by private insurance. Do you approve or not approve of the government paying lower fees for Medicare and Medicaid patients if it results in higher fees for everyone else?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Approve	22	5	7	10	10	12
Do not approve	74	95	87	90	90	77
Not sure/no opinion	4	-	5	-	-	8

Table 5-2

**ATTITUDES TOWARD MEDICARE AND MEDICAID
"COST-SHIFTING": THE PUBLIC BY INSURANCE COVERAGE**

Base: Public cross section

Q. The two main government health care programs paid for out of taxes are Medicare, which is mainly for people 65 and over, and Medicaid, which is for people with low incomes. Current and proposed government regulations limit the amount the government will pay hospitals and doctors for Medicare and Medicaid patients. Some doctors and hospitals, therefore, are paid less for Medicare and Medicaid patients, and charge higher fees for patients who pay their own bills or are covered by private insurance. Do you approve or not approve of the government paying lower fees for Medicare and Medicaid patients if it results in higher fees for everyone else?

	Total	Type of Health Care Coverage				
		Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1016	300	94	687	75
	%	%	%	%	%	%
Approve	22	23	17	20	24	15
Do not approve	74	73	76	75	73	81
Not sure/no opinion	4	4	6	5	3	3

Attitudes Toward Health Care Coverage for the Unemployed

The American public appears to agree in principle with the idea of a health care program for the unemployed, but they are reluctant to be in favor of such a program if it means a higher direct or indirect cost to themselves.

The American public was presented with four proposals for financing health coverage for the unemployed. The proposal favored by more of the public than any other is one that requires employers to maintain benefits for laid-off workers for six months and to contribute in some form toward providing another twelve months' coverage.

Whereas 65% favor financing health care coverage for the unemployed at the state government level and 59% favor financing at the federal government level, only 42% favor financing such a program from new taxes on individuals' employer-paid health insurance premiums (Table 5-3).

As would be expected, the unemployed favor all the proposals to a greater extent than do those who are not unemployed (Table 5-4). However, 55% of the unemployed group do not favor such programs if it means higher direct or indirect cost to other people (Table 5-6). In fact, those employed full-time (45%) or retired (44%) are more likely to favor such a program, despite cost to themselves.

Among the professional groups, the union leaders are most likely to favor all proposed programs for financing health care for the unemployed, except through taxes on premiums, even at cost to other people (Tables 5-3 and 5-4).

At the other extreme are corporate benefits officers, majorities of whom do not favor any of the proposals. The other three professional groups favor extension of employer-paid benefits or financing at the state government level more than they do financing at the federal government level or through taxes on premiums. In fact, majorities in these three groups clearly do not favor the latter two proposals. These three groups resemble union leaders in that they favor health care coverage for the unemployed despite cost to others (Table 5-5).

The idea of establishing a tax on third-party payers to finance extension of benefits to the unemployed is in clear disfavor among all professional groups except union leaders, who are evenly split on the issue.

Observation:

If a program is established to provide health care coverage for the unemployed, then its costs will clearly be passed on to the American public, directly or indirectly. Despite this, it is impressive to see that a little over 40% of the public favor such a program. There is indeed "no free lunch" and people seem to recognize that.

Table 5-3

**ATTITUDES TOWARD HEALTH CARE COVERAGE
FOR THE UNEMPLOYED: THE PUBLIC AND PRO-
FESSIONALS COMPARED**

Q: One group that is largely not covered by health insurance is the unemployed. Several proposals have been made to ensure that this group gets some type of health care coverage. For each proposal I read to you, please tell me whether or not you favor it.

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Requiring employers, by law, to maintain health insurance benefits for laid-off workers for six months and contribute to a pool of funds to provide another twelve months of coverage						
Favor	71	57	47	58	34	77
Do not favor	27	41	51	40	66	19
Not sure/no opinion	2	1	2	2	-	4
Encouraging but not requiring each state to pay for health care coverage for unemployed workers						
Favor	65	61	63	52	42	69
Do not favor	33	37	36	48	57	31
Not sure/no opinion	2	-	1	-	1	-
Financing health care coverage for the unemployed by establishing a federal government program similar to the Medicare program						
Favor	59	36	29	20	22	77
Do not favor	38	62	69	80	77	19
Not sure/no opinion	2	-	2	-	1	4
Financing health care coverage for the unemployed from new taxes on individuals' employer-paid health insurance premiums that exceed a set amount						
Favor	42	41	30	28	13	35
Do not favor	54	57	66	72	86	62
Not sure/no opinion	4	2	4	-	1	4
Establishing a tax on third-party payers to finance extension of benefits for the unemployed						
Favor	x	27	16	14	11	42
Do not favor	x	72	82	86	87	46
Not sure/no opinion	x	1	2	-	1	12

*Less than 0.5%.

x = Not asked

Table 5-4

ATTITUDES TOWARD HEALTH CARE COVERAGE FOR THE UNEMPLOYED: THE PUBLIC BY OCCUPATIONAL STATUS

Base: Public cross section

Q One group that is largely not covered by health insurance is the unemployed. Several proposals have been made to ensure that this group gets some type of health care coverage. For each proposal I read to you, please tell me whether or not you favor it.

	Total	Occupational Status				
		Employed Full-Time	Employed Part-Time	Retired	Unemployed	Student/ Housewife
No. of Respondents	1501	800	159	272	88	172
Requiring employers, by law, to maintain health insurance benefits for laid-off workers for six months and contribute to a pool of funds to provide another twelve months of coverage						
Favor	71	70	71	68	81	71
Do not favor	27	28	29	27	17	26
Encouraging but not requiring each state to pay for health care coverage for unemployed workers						
Favor	65	62	66	65	77	65
Do not favor	33	36	33	30	20	32
Financing health care coverage for the unemployed by establishing a federal government program similar to the Medicare program						
Favor	59	55	56	62	81	60
Do not favor	39	43	41	34	17	34
Financing health care coverage for the unemployed from new taxes on individuals' employer-paid health insurance premiums that exceed a set amount						
Favor	42	36	43	47	57	39
Do not favor	54	59	53	45	38	58

Table 5-5

**ATTITUDES TOWARD HEALTH CARE COVERAGE FOR THE UNEMPLOYED
DESPITE COST TO OTHERS: THE PUBLIC AND PROFESSIONALS COMPARED**

Q. Do you favor providing health care coverage for unemployed workers and their families *even if* it means that the cost to other people will increase directly or indirectly through higher medical or insurance bills or increased taxes?

	Public Cross Section	Physician Leaders	Hospital Administrators	Insurance Executives	Corporate Benefits Officers	Union Leaders
No. of Respondents	1501	100	100	50	250	26
	%	%	%	%	%	%
Favor	43	67	58	66	42	73
Do not favor	53	28	36	34	55	19
Not sure/no opinion	3	4	4		3	4

Table 5-6

**ATTITUDES TOWARD HEALTH CARE COVERAGE FOR THE UNEMPLOYED
DESPITE COST TO OTHERS: THE PUBLIC BY OCCUPATIONAL STATUS**

Base: Public cross section

Q. Do you favor providing health care coverage for unemployed workers and their families *even if* it means that the cost to other people will increase directly or indirectly through higher medical or insurance bills or increased taxes?

	Total	Occupational Status				
		Employed Full-Time	Employed Part-Time	Retired	Unemployed	Student/ Housewife
No. of Respondents	1501	800	159	272	88	172
	%	%	%	%	%	%
Favor	43	45	39	44	39	37
Do not favor	53	53	58	50	55	58
Not sure/ no opinion	3	2	3	5	6	4

APPENDIX A: SURVEY METHOD

Sample Design

Six different samples were surveyed in this study. The sample design for each is detailed below.

1. The American Public:

A nationwide cross section of 1,501 adults, 18 years or over, was interviewed for this study. The sample was generated by the random-digit-dialing method and was based on an unclustered sampling frame, stratified by region and by the Census Bureau's "size of place" designations.

2. Physician Leaders:

100 interviews were completed with physicians who represent the leadership of state, local, and specialty medical societies throughout the nation. A random selection procedure was used to draw this sample from the 1981 AMA directory of officials and staff.

3. Hospital Administrators:

100 hospital administrators were interviewed. A sample of hospitals and their administrators was drawn from the *American Hospital Association Guide*, 1981 edition. The sample selection procedure involved selecting the largest hospital from each region in the directory to assure national representation.

4. Health Insurance Executives:

50 interviews were completed with senior health insurance executives of the larger insurance companies with group health lines. The sample was drawn from three sources:

- Blue Cross/Blue Shield plans with memberships of 1,000,000 or more for regular group plans.
- Insurance companies from the Fortune 50 list (1982) who have accident and health insurance (SIC: 6321) and hospital and medical service (SIC: 6324) plans.
- Companies listed in SIC's 6321 and 6324 of the *Dun & Bradstreet Million Dollar Directory*.

5. Corporate Benefits Officers:

250 interviews were completed with corporate benefits officers responsible for and knowledgeable about their companies' health care plans. A random selection procedure was used to draw the sample from the 1982 Fortune 1,000 list of industrial companies and the list of 50 nonindustrials in all categories, excluding insurance companies and utilities.

6. Union Leaders:

26 interviews were completed with leaders within major trade unions who had primary responsibility for health care benefits. The sample was drawn from a list of labor unions found in the 1983 National Trade and Professional Associations directory. To ensure that the large unions were represented, those with an operating budget of more than 5,000,000 were selected first, and then a random selection procedure was used to select from unions with operating budgets of from \$2,500,000 to \$5,000,000.

Interviewing

Interviews were conducted by telephone from May 13 through June 7, 1983. The public sample was interviewed from 5:00 p.m. to 10:00 p.m. (local time) on weekdays, and from 10:00 a.m. to 10:00 p.m. (local time) on weekends. The professional samples (items numbered 2 through 6 above) were interviewed on weekdays from 9:00 a.m. to 5:00 p.m. Where necessary, appointments were made to interview the relevant individual within the organization contacted.

Up to three callback attempts were made to reach the selected respondent. On the average, the interviews with the public sample lasted 32 minutes, and those with professional groups lasted 27 minutes.

The response rates were: 57% for the public sample, 78% for the sample of physician leaders, and 83% across the other professional groups.

Data Processing

The editing, coding, and data processing of all questionnaires were conducted by Louis Harris and Associates.

Codes were developed for responses to open-end questions, with only those responses given by less than 0.2% of the respondents being coded as "other" responses.

The data were analyzed and tabulated separately for each of the six samples. The responses given by the public sample were cross-tabulated against the following variables:

- Total sample;
- Region;
- Sex;
- Employment status;
- Income;
- Labor union family;
- Age;

- Ethnicity;
 - Family size;
 - Political philosophy;
 - Health care coverage through self or family;
 - Health status;
 - Type of health coverage;
 - Contribution to insurance premium;
 - Those who did not get needed medical help;
 - Number of outpatient visits by any member of the family; and
 - Overnight hospital stay by any member of the family.
- Weighting of the Data*

Weighting of the Data

The data from the public sample were weighted to be representative of the population of U.S. households. The weights were based on the 1980 census counts for age, race, sex and income.

Sampling Error

The table below indicates the sampling error associated with the various sample sizes and the reported

sample percentages at the 95% confidence level:

Sample Size	Reported Sample Percentage				
	10% or 90%	20% or 80%	30% or 70%	40% or 60%	50%
1500	1.5	2.0	2.3	2.5	2.5
250	3.7	4.9	5.6	6.1	6.2
100	5.9	7.8	8.9	9.6	9.6
50	8.3	11.1	12.7	13.6	13.8

1 It should be noted that the professional group samples were drawn from small and defined universes. Therefore, the effective sampling error for these samples would be considerably smaller than the ones reported in this table.

Thus, if a reported sample percentage of 40% is based on a sample of 1,500 cases (e.g., the public sample), then the 95% confidence interval containing the population percentage is 40 ± 2.5 or 37.5% to 42.5%.

Copies of the questionnaires used in this study are available upon request from Louis Harris and Associates.

APPENDIX B: PROFILES OF THE PUBLIC SAMPLE

Profiles of the Public Sample

Table B-1 presents the demographic profile of the survey sample of the American public.

Table B-2 presents the weighted data on the type of health care coverage reported by the total sample and categorized by employment status.

Table B-3 presents the weighted data on the usage of health care facilities by the total sample, those in excellent or good health versus those in poor or fair health, and those with different types of health care coverage.

Table B-1

DEMOGRAPHIC PROFILE OF THE PUBLIC SAMPLE

	Unweighted	Weighted		Unweighted	Weighted
	%	%		%	%
Total	100	100	Total	100	100
Region¹			Age		
Northeast	23	23	18-29 years	27	30
North Central	27	27	30-39 years	24	20
South	32	32	40-49 years	14	13
West	18	18	50-64 years	20	21
			65 and over	15	16
Sex			Ethnicity		
Male	48	47	White	83	84
Female	52	53	Black	9	10
Employment Status			Hispanic	6	6
Employed full-time	53	51			
Employed part-time	11	11	Family Size		
Retired	18	19	1	17	17
Unemployed	6	6	2	30	30
Student/housewife	12	12	3	20	20
			4 or more	32	32
Income			Political Philosophy		
\$7,500 or less	12	14	Conservative	38	38
\$7,501 to \$15,000	17	18	Middle-of-the-road	39	39
\$15,001 to \$25,000	27	21	Liberal	17	17
\$25,001 to \$35,000	20	18			
\$35,001 or more	18	22			

¹ Definition of geographic regions:

Northeast: Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont.

North Central: Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, Wisconsin.

South: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia.

West: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming.

Table B-2

TYPE OF HEALTH CARE COVERAGE

Q. Now I'd like to talk about the different kinds of health plans or health insurance that people have, including those provided by the government. As I read each of the following health plans, please tell me whether or not you are covered by it.

	Total	Occupational Status				
		Employed Full-Time	Employed Part-Time	Retired	Unemployed	Student/Housewife
No. of Respondents	1501	800	159	272	88	172
Health insurance through work or union	86	80	63	36	50	62
Health insurance through some other group	26	23	27	36	21	24
Health insurance bought directly by yourself or your family	36	29	43	49	39	36
Medicare, that pays health care bills for people aged 65 and over and for some disabled people	20	6	8	74	12	12
Medicaid or public aid	7	3	6	13	23	5
Any other health insurance	2	1	2	3	3	3
None	5	5	9	2	11	5

Table B-3

FAMILY USE OF HEALTH CARE IN THE PAST TWELVE MONTHS

- Q. How many visits, *excluding* overnight hospital stays, did you and all members of your family living with you make to a doctor's office, outpatient clinic, hospital emergency room, or any other place for medical care during the past twelve months — that is, since (DATE ONE YEAR AGO) 1982?
- Q. Have you or has anyone in your family living with you been a patient overnight in a hospital during the past twelve months, since (DATE ONE YEAR AGO) 1982?

	Total	Health Status		Type of Health Care Coverage				
		Excellent/ Good	Fair/ Poor	Through Work or Union	Medicare	Medicaid	Other	None
No. of Respondents	1501	1253	247	1016	300	94	687	75
	%	%	%	%	%	%	%	%
Number of visits to health care facilities (excluding overnight hospital stays)								
None	9	9	7	6	9	13	9	26
1 to 5	32	34	25	32	31	29	32	33
6 to 15	37	37	36	38	36	30	38	27
16 to 25	10	10	15	11	12	11	10	10
26 or more	11	10	15	11	11	16	10	3
Anyone in the family has been a patient overnight in a hospital								
Yes, has been a patient	33	30	48	34	36	33	36	20
No, has not been a patient	67	70	52	66	64	67	64	80



The Equitable Healthcare Survey II:

PHYSICIANS' ATTITUDES TOWARD COST CONTAINMENT

Conducted for
The Equitable Life Assurance Society of the United States

March 1984

Project Directors :

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INTRODUCTION

This survey was designed to provide a detailed assessment of the attitudes of American physicians on the subject of health care costs and cost-containment policies. It is based on 500 interviews conducted in January and February 1984 with a representative cross section of physicians.

In the summer of 1983, Louis Harris and Associates conducted a major study, **The Equitable Health-care Survey: Options for Controlling Costs**, for The Equitable Life Assurance Society of the United States. That study provided a detailed assessment of the attitudes of the American public, employers, unions, hospital administrators, the health insurance industry, and physicians who head state and local medical societies (referred to as "physician leaders") on the subject of health care costs and cost-containment policies. The findings of that study were publicly released in October 1983. The present survey was designed to complement that study by examining the views of a national cross section of practicing physicians on the same subject.

The questionnaire used in this study was virtually identical to the one used in the earlier study. Therefore, it is possible to compare the views of the physicians surveyed here with those of physician leaders, hospital administrators, and the American public, all surveyed earlier. While the focus of this report is the survey of physicians, important comparisons with the groups interviewed in the earlier study are included.

Survey Content

Topics explored in the survey are outlined below:

- General attitudes toward the health care system in the U.S. and the system's particular strengths and weaknesses;
- Perceptions of the reasons for health care cost escalation and possible solutions;
- Attitudes toward a broad range of cost-containment policies and programs in terms of their anticipated effectiveness and acceptability; and

- Attitudes toward various proposed trade-offs between better coverage on the one hand and greater cost to the patient on the other hand.

The content of the survey reflects an interest in not only providing an analysis of the problems of health care costs but also in providing information on attitudes toward various proposed solutions to those problems.

A Note on the Tables

Percentages in the tables may not add to 100% because of rounding or the acceptance of multiple responses. And, where indicated, percentages in some tables add up to less than 100% because of the exclusion of "not sure" responses. All tables show unweighted percentages for the professional groups and weighted percentages for the public sample, and they indicate the unweighted bases in each group.

Acknowledgements

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Final responsibility for the survey design and the findings and conclusions contained in this report rests with Louis Harris and Associates.

SURVEY HIGHLIGHTS

This summary provides an overview of the opinions of physicians on issues explored in this survey. Where pertinent, comparisons are made with the findings of the earlier survey.* Interested readers are urged to examine the full report for comparisons between the opinions of physicians surveyed in this study and those of physician leaders, hospital administrators, and the American public, surveyed earlier on all the major issues.

1. Less than half of all physicians believe that the American health care system works well and needs only minor changes.

This finding contrasts sharply with the views of physicians who head state, local, and specialty medical societies (physician leaders), two-thirds of whom believe that the nation's health care system works well.

These responses are strikingly different from those of the American people, only 21% of whom believed, in 1983, that the health care system was working pretty well, and most of whom felt that fundamental changes were needed or that the system needed to be completely rebuilt.

These differences reflect the gulf that exists between physicians' attitudes and public opinion on the subject of health care costs and on the need for action to contain them.

2. There is no consensus among physicians with regard to priorities for change in the nation's health care system.

The answers given most frequently in reply to a question concerning which one change they would most like to see relate to improved access to health care, cost containment, and less government interference and regulation of the health care system.

3. Most physicians are satisfied with the availability and quality of health care generally, with their own health insurance benefits, and with the cost of health care.

However, fully 41% of physicians are dissatisfied with the total cost of care, and 32% are dissatisfied with out-of-pocket costs.

4. A majority (59%) of physicians think that the cost of hospitalization is unreasonably high.

However, sizable majorities believe that the costs of doctors' visits, laboratory tests, and health insurance are reasonable. In contrast to the opinion of a majority of physician leaders who think the cost of prescription drugs is reasonable, physicians reveal only a plurality of opinion regarding this issue.

5. Majorities, in most cases large majorities, of physicians think that seven different factors have contributed significantly to the rise in health care spending over the last few years.

However, only a minority (17%) think that unit-cost inflation — the increasing cost of the same services — is the main reason. This latter view contrasts sharply with that of the American public, 44% of whom feel that unit-cost inflation is the main reason for increased spending.

The factors most widely believed by physicians to have had a major impact on health care spending are:

- The increasing use of expensive equipment and technology;
- The fact that the population as a whole is getting older;
- The growth of expensive malpractice suits and malpractice insurance;
- The increased availability of government-funded programs such as Medicare and Medicaid;
- The increased availability of employer-provided health insurance;
- Doctors ordering more laboratory tests than are necessary; and
- Unnecessary hospitalization.

*The Equitable Healthcare Survey: Options for Controlling Costs. Louis Harris and Associates, August 1983.

6. A majority of physicians believe that the third-party payment system, as it exists today, is a major contributor to increased health care spending.

While large majorities of physicians believe that the third-party payment system, the practice of defensive medicine, and the aging of the population have contributed to increased health care spending, there is a plurality of opinion on the idea that the increase is due to a lack of competitive pricing in the health care industry.

Younger physicians and physicians who are not members of AMA tend to agree that a lack of price competition contributes to health care cost inflation.

7. A majority of physicians believe that the present health care system is price competitive.

Physicians' views on this subject are in sharp contrast to those of hospital administrators and the public. A majority of the public (76%) believe that one of the problems of health care is that there is no competition to keep prices down. Furthermore, majorities of hospital administrators, insurance executives, corporate benefits officers, and union leaders all share the public's view that the nation does not have a price-competitive system.*

In this context, it is important to note that only 16% of the public have ever chosen a physician because his or her fees were lower than those of another doctor.*

8. There is no agreement among physicians as to the proportion of all health care costs that are incurred by the highest spending 10% of the population.

The median response is that 56% of all spending can be attributed to this 10% of the population, a figure somewhat lower than available data and other estimates would suggest.

Physicians believe that the main reasons for the increased concentration of health care spending on a small proportion of the public are: the aging of the population, the use of more expensive procedures to save or prolong life, the unhealthy lifestyles of some Americans, the use of new medical technology, and the overuse of health care services by a few people.

9. Reactions to specific health care cost-containment policies vary from almost unanimous acceptance to overwhelming opposition.

In general, there is a relatively high correlation between the perceived effectiveness of a policy and its acceptability. Where a policy is perceived to be effective, it is generally acceptable. Where it is not effective, it is generally not thought to be effective. However, there are a few important exceptions to this rule.

10. By large majorities, physicians believe that most policies which would increase cost-sharing by patients would be both effective and acceptable.

Specific policies endorsed by large numbers of physicians relate to increased deductibles and copayments, and requiring patients to pay a part of their employer-paid insurance premiums. On the other hand, less than half of the physicians view a new tax on the top portion of large health insurance premiums as an effective or acceptable cost-containment measure.

11. Overwhelming majorities of physicians endorse changes in the health care system that would reduce hospitalization.

Alternatives to hospitalization in the care of the chronically ill or for tests and minor surgery are considered both effective and acceptable in containing health care spending. However, certification by insurance companies prior to nonemergency hospitalization is acceptable to less than half of the physicians.

*The Equitable Healthcare Survey: Options for Controlling Costs. Louis Harris and Associates, August 1983.

- 12. Physicians view the proposal to require second opinions prior to nonemergency surgery as generally acceptable.**

However, there is some doubt about its effectiveness in controlling costs.

- 13. Discouraging the duplication of expensive equipment and specialists at nearby hospitals is a proposal acceptable to almost two-thirds of the physicians.**

Almost three-fourths of the group consider this an effective means for containing health care costs.

- 14. Utilization reviews are thought to be at least somewhat effective, but a sizable minority (44%) do not regard them as acceptable.**

- 15. The proposal to fix fees paid to doctors and hospitals based on diagnosis-related groups (DRG's) is unacceptable to a clear majority of physicians.**

However, over half of the physicians concede that it is an effective cost-containment strategy.

- 16. The notion of government price controls draws the greatest consensus of negative responses from physicians.**

Although almost half agree that such controls would reduce health care spending, fully 85% find the proposal unacceptable.

- 17. Health Maintenance Organizations (HMO's) and preferred provider plans are unacceptable to a majority of physicians.**

However, medical opinion is more receptive to a system where a primary care physician receives a predetermined fee for providing basic medical care and is also responsible for authorizing additional health care services.

- 18. Large majorities of physicians consider insurance plans that provide individual incentives for healthy living or group incentives for below target expenditures to be both effective and acceptable in controlling health care costs.**

- 19. Changes in laws relating to malpractice that would reduce the pressure on doctors to practice defensive medicine are generally thought to be both effective and acceptable.**

- 20. Most physicians believe that changing anti-trust laws so that third-party payers can join together to negotiate fees with providers would be an effective cost-containment strategy.**

A smaller majority consider this proposal acceptable.

- 21. Business coalitions formed to control health care costs are seen as both effective and acceptable by a majority of physicians.**

- 22. There is some resistance among physicians to encouraging the use of nurse practitioners, midwives, and physicians' assistants instead of physicians.**

While over 50% find this change unacceptable, a large minority (46%) also believe that this would not be an effective means for controlling costs.

- 23. While most physicians believe that reducing the use of so-called "heroic" medicine would be effective in controlling health care spending, a smaller majority find this proposal acceptable.**

- 24. There is overwhelming disapproval of the concept of cost-shifting.**

Policies that result in a shift in the cost of treatment for Medicare and Medicaid patients to fees paid by private-sector patients are looked upon with disfavor by most physicians.

25. Health care coverage for the unemployed is favored by most physicians, even if it means additional direct or indirect cost to other people.

While the majority of physicians favor providing this coverage by extending employer-paid insurance or by encouraging each state to finance it, they oppose financing this coverage through a federal program or from any type of new tax.

26. In general, physicians in the South are more conservative.

They are more satisfied with the status quo and are least likely to accept policies which would adversely affect their income.

27. In most instances, younger physicians (i.e., physicians who have graduated more recently) are more receptive to the proposed changes in the health care system than are older physicians.

The changes that older physicians endorse in larger numbers than younger physicians are those that would shift additional costs to the patient. AMA members, who tend to be older than nonmembers, also tend to be more conservative than nonmembers in accepting changes in the health care system that would place constraints on the price or use of health care services and on equipment purchases.

28. Physicians are out of step with the nation on many key issues.

They are less critical of the status quo, much more likely to believe that the health care system is price competitive, and much less willing to accept alternatives to the traditional fee-for-service, doctor-patient relationship than the public, hospital administrators, employers, union leaders, or insurance executives.*

29. However, practicing physicians are more likely to see the need for change than are their elected leaders.

They are also somewhat more willing to accept alternative delivery systems.

CHAPTER 1: GENERAL ATTITUDES TOWARD THE HEALTH CARE SYSTEM

Overall View of the Health Care System

Less than half of all physicians are satisfied with the nation's health care system. While 48% of all physicians surveyed believe that on the whole the American health care system works pretty well and that only minor changes to the system are needed, an equal number believe that fundamental changes are needed to make the health care system better. Very few physicians (3%) believe that there is so much wrong with the American health care system that it is necessary to completely rebuild it.

Whereas a majority (54%) of the physicians who are members of the American Medical Association (AMA) view the health care system as working pretty well, a majority (54%) of those who are not members of AMA view the system as needing fundamental changes to make it work better. The former view is also held by a clear majority of physicians in the South (55%) and those who graduated eleven to twenty years ago (55%). The latter view is held by a clear majority of physicians in the West (57%), and by smaller majorities of physicians who graduated less than six years ago (52%) or over twenty years ago (51%). There is a plurality of opinion on this issue among physicians in the East and Midwest, and among those who graduated six to ten years ago (Table 1-1).

Table 1-1

OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM: PHYSICIANS BY AMA MEMBERSHIP, REGION, AND YEARS SINCE GRADUATION

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

	Total Physicians	AMA Membership		Region				Years Since Graduation			
		Member	Non- member	East	Mid- west	South	West	5 or Less	6-10	11-20	21 or More
Base	500	266	232	150	112	128	110	73	120	119	175
	%	%	%	%	%	%	%	%	%	%	%
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	48	54	41	46	50	55	40	47	48	55	44
There are some good things in our health care system, but fundamental changes are needed to make it work better	48	43	54	48	47	41	57	52	47	42	51
The American health care system has so much wrong with it that we need to completely rebuild it	3	2	3	5	2	2	2	1	5	1	3
Not sure	1	1	1	1	1	1	—	—	1	1	1

Compared to the physicians surveyed in this study, physician leaders reveal a greater consensus of opinion, and believe that the system works pretty well (Table 1-2). On the other hand, the physicians' views contrast sharply with that of the American public, fully 25% of whom hold the view that the American health care system has so much wrong with it that we need to completely rebuild it. Only 21% of the American public feel that the system works pretty well, while 50% believe it needs fundamental changes to make it work better.

Table 1-2

**OVERALL VIEWS OF THE AMERICAN HEALTH CARE SYSTEM:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. Which of the following statements comes closest to expressing your overall view of the American health care system?

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
On the whole the health care system works pretty well, and only minor changes are necessary to make it work better	48	68	41	21
There are some good things in our health care system, but fundamental changes are needed to make it work better	48	32	56	50
The American health care system has so much wrong with it that we need to completely rebuild it	3	—	2	25
Not sure	1	—	1	4

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983.

Suggested Changes for the Health Care System

There is a wide diversity of opinion among physicians regarding the single change they would most like to see in the health care system. A variety of changes related to better access to health care are given top priority by 20% of the physicians, while 14% cite a variety of changes related to cost containment, and 14% would like to see less government interference and regulation. Some would like to see more public education about medical matters (5%), more investigation of third-

party reimbursement (5%), and better regulation of malpractice suits (5%).

Physicians, in general, differ from physician leaders in that they give priority to access-related changes in greater numbers, and to public education regarding medical matters in smaller numbers, than do physician leaders (Table 1-3). They differ from both hospital administrators and the American public in giving priority to changes related to cost reduction in smaller numbers, and to a reduction in government interference and control in greater numbers, than do those two groups.

Table 1-3

PRIORITY FOR CHANGES IN THE U.S. HEALTH CARE SYSTEM: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED

Q. If there were *one* change you could make in the health care system in the United States, what would it be?

	Physicians	Physician Leaders [†]	Hospital Administrators [†]	Public [†]
Base	500	100	100	1501
	%	%	%	%
Cost-Reduction or Control (Total)	14	14	19	23
Control or limit costs	9	8	13	12
Lower hospital costs	2	2	—	5
Government should control health care/insurance costs	2	2	3	2
Reduce doctors' charges	1	2	3	4
Access-Related Changes (Total)	20	13	17	24
Assure availability of equal quality care for all	9	4	2	5
For those who can't afford it, cut costs/provide financial support	5	3	7	5
Need better insurance coverage; reevaluate coverage	5	6	8	3
More/better care for the elderly; more inclusive Medicare	1	—	—	11

(Continued)

Table 1-3 (Continued)

**PRIORITY FOR CHANGES IN THE U.S. HEALTH CARE SYSTEM:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Other Specific Changes				
Less government interference/ regulation	14	15	6	1
Public education regarding medical programs and costs	5	13	4	2
More investigation of third- party reimbursement	5	6	3	*
Better regulation of malprac- tice suits	5	2	—	—
People should pay more of the cost of health care	3	8	6	1
Socialize medicine, national health service	3	—	5	8
Medicare/Medicaid should pro- vide uniform reimbursement	3	—	2	1
Less impersonal doctor/patient relationship	2	6	3	3
More doctors	2	1	2	2
Encourage formation/use of HMO's	2	1	3	*
Better doctors: responsibility, proficiency, attitude	2	—	2	1
Better hospitals	2	1	—	2
Change fee for service to other form of payment	1	2	8	1
Preventive medicine should be implemented/augmented	1	3	2	2
Eliminate waste, fraud, graft, pilfering, handouts	1	—	4	2
Eliminate unnecessary use of facilities, Medicaid, Medicare	1	1	—	1
Need more clinics	1	—	—	1
Investigate/regulate insurance companies, assure policy is understood	*	—	—	1
All Other Reasons Mentioned (Total)	6	1	8	4
Not sure	8	5	2	18

*Less than 0.5%

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983

Satisfaction and Dissatisfaction with Health Care

Large majorities of physicians are satisfied with the availability and quality of health care and with their health insurance benefits, while a sizable minority express dissatisfaction with the various costs of health care. Fully 41% express some degree of dissatisfaction with the total cost of health care, and 32% are dissatisfied with the out-of-pocket cost of health care. Physician leaders and hospital administrators share these views in similar numbers. The majority of the American public, on the other hand, are dissatisfied with these costs, but are satisfied with the availability and quality of health care, as well as their health insurance benefits (Table 1-4).

Table 1-4

**SATISFACTION WITH VARIOUS ASPECTS OF HEALTH CARE:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. I will mention several different aspects of health care. Please say for each one whether—in the light of your own experience—you are very satisfied with it, somewhat satisfied, somewhat dissatisfied, or very dissatisfied.

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1,501
	%	%	%	%
The quality of health care generally				
Very satisfied	62	84	58	30
Somewhat satisfied	30	16	34	47
Somewhat dissatisfied	5	—	5	14
Very dissatisfied	1	—	—	6
The availability of health care				
Very satisfied	51	60	49	39
Somewhat satisfied	36	33	37	36
Somewhat dissatisfied	10	7	7	16
Very dissatisfied	1	—	3	7
Your health insurance benefits				
Very satisfied	47	55	52	37
Somewhat satisfied	35	34	27	33
Somewhat dissatisfied	13	7	13	15
Very dissatisfied	3	4	6	10
The out-of-pocket cost of health care				
Very satisfied	22	26	30	16
Somewhat satisfied	40	41	37	26
Somewhat dissatisfied	25	25	22	26
Very dissatisfied	7	5	11	28
The total cost of health care, including what both you and your insurance pay				
Very satisfied	18	27	17	18
Somewhat satisfied	37	34	36	28
Somewhat dissatisfied	30	28	31	25
Very dissatisfied	11	11	15	25

Note: Those "not sure" or for whom item was "not applicable" are not shown on this table.

¹ Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983.

Physicians' attitudes towards the cost of specific health care services vary substantially. Seventy-four percent of physicians consider the cost of doctors' visits reasonable and 60% consider the cost of health insurance reasonable, while a smaller majority (55%) think that laboratory tests are reasonable. By contrast, a noteworthy majority (59%) of physicians view the cost of hospitalization as unreasonable. This view on hospitalization cost is shared by a majority (over 60%) of physician leaders and the American public, but only by a minority (40%) of hospital administrators.

Physicians' views are almost evenly divided on whether or not the cost of prescription drugs is reasonable. This stance differs significantly from that of physician leaders, 71% of whom consider prescription drugs as reasonable in cost.

In general, there is a lower consensus of opinion among physicians than among physician leaders regarding the cost of the various health care services (Table 1-5).

Table 1-5
ATTITUDES TOWARD THE COST OF HEALTH CARE SERVICES:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED

Q. Do you think the cost of (READ EACH ITEM) is very reasonable, somewhat reasonable, somewhat unreasonable, or very unreasonable for what you get?

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Doctors' visits				
Very reasonable	27	35	10	13
Somewhat reasonable	47	50	47	32
Somewhat unreasonable	17	12	34	29
Very unreasonable	2	—	7	22
Health insurance				
Very reasonable	12	17	17	20
Somewhat reasonable	48	55	49	31
Somewhat unreasonable	31	25	25	24
Very unreasonable	6	2	8	20
Laboratory tests and X-rays outside hospitals and clinics				
Very reasonable	17	26	8	9
Somewhat reasonable	38	48	45	24
Somewhat unreasonable	27	22	27	29
Very unreasonable	10	3	9	27
Prescription drugs				
Very reasonable	8	15	12	14
Somewhat reasonable	41	56	39	30
Somewhat unreasonable	38	21	36	28
Very unreasonable	8	6	10	26
Hospitalization				
Very reasonable	5	8	17	11
Somewhat reasonable	33	27	43	22
Somewhat unreasonable	40	51	25	27
Very unreasonable	19	12	15	26

Note: Those "not sure" or for whom item was "not applicable" are not shown on this table.

¹Source: The Equitable Healthcare Survey: Options for Controlling Costs, Louis Harris and Associates, August 1983.

CHAPTER 2: REASONS FOR INCREASED SPENDING ON HEALTH CARE

Physicians, in contrast with physician leaders, hospital administrators, and the American public, display a fair degree of unanimity in their views regarding the principal reason for increased health care spending. While 59% of the physicians consider the use of expensive treatments and equipment as the main reason for increased spending, only 18% cite increased utilization, and 17% cite unit-cost inflation as the main reason.

Although both physician leaders and hospital administrators are most likely to view expensive treatment and equipment as the main reason for increased health care spending, a sizable number (31% and 29%, respectively) lay the blame on increased utilization. The American public, on the other hand, is most likely (44%) to view unit-cost inflation as the principal reason for the increased spending, followed by the use of expensive treatments and equipment (34%), and lastly, increased utilization (17%) (Table 2-1).

Table 2-1

MAIN REASON FOR INCREASED SPENDING ON HEALTH CARE SERVICES: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED

Q. The amount of money spent on health care services has been growing rapidly over the last fifteen years. Total national health care spending has gone from \$51 billion in 1967 to over \$300 billion last year. The increased amount of money spent on health care services is partly a result of *people using more health care services than they used to*, partly a result of *the use of new and more expensive treatments and equipment*, and partly a result of *the increasing cost of the same services*.

Which one of these three do you think is the main reason for the increased spending on health care services?

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
The use of new and more expensive treatments and equipment	59	46	49	34
People using more health care services than they used to	18	31	29	17
The increasing cost of the same services	17	19	16	44
Not sure	6	3	4	4

¹Source: The Equitable Healthcare Survey: Options for Controlling Costs, Louis Harris and Associates, August 1983.

Table 2-2 indicates the extent to which each of ten specific practices is believed to have contributed to the rise in health care spending. The factors believed by over 75% of the physicians to have contributed to this rise in spending are:

- The increasing use of expensive new equipment and technology;
- The fact that the population as a whole is getting older;
- The growth of expensive malpractice suits;
- The increased availability of government-funded programs such as Medicare and Medicaid;
- The increased availability of employer-provided health insurance; and
- Doctors ordering more laboratory tests than are necessary.

A modest majority (56%) believe that patients being hospitalized for minor ailments has contributed to increased health care spending, while a marginal majority of physicians reject the notion that the rise in spending is due to the absence of competitive pricing or because people are staying in hospitals longer than is necessary.

Physicians' views on each factor appear to be slightly less defensive of their own profession than those of physician leaders. Physicians' views differ from those of hospital administrators and the American public in degree rather than direction on most factors. The most notable exception is the opinion of these groups on whether or not a lack of price competition among providers contributes to increased health care spending. While physicians marginally reject this notion, hospital administrators and the public endorse it by a wide margin.

Table 2-2

**SPECIFIC REASONS FOR THE RISE IN HEALTH CARE SPENDING:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. I will read you some reasons that are given for the rise in health care spending over the last few years. For each reason, please tell me if you think it has contributed very much, somewhat, not very much, or not at all to the increased health care spending in this country.

	Physicians	Physician Leaders [†]	Hospital Administrators [†]	Public [†]
Base	500	100	100	1501
	%	%	%	%
The increasing use of expensive new equipment and technology				
Very much	58	47	45	50
Somewhat	38	47	54	40
Not very much	3	5	1	6
Not at all	—	—	—	1
The fact that the population as a whole is getting older, and older people require more medical services				
Very much	53	65	52	32
Somewhat	40	34	39	45
Not very much	6	1	7	16
Not at all	1	—	2	5

Table 2-2 (Continued)

**SPECIFIC REASONS FOR THE RISE IN HEALTH CARE SPENDING:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
The growth of expensive malpractice suits which require doctors to pay for expensive malpractice insurance				
Very much	46	40	20	44
Somewhat	43	51	64	36
Not very much	10	9	15	12
Not at all	1	—	1	4
The increased availability of government-funded programs such as Medicare and Medicaid				
Very much	34	56	50	37
Somewhat	51	36	36	42
Not very much	11	8	10	13
Not at all	4	—	2	5
Doctors ordering more laboratory tests than are necessary				
Very much	28	11	26	46
Somewhat	56	58	54	34
Not very much	13	28	18	13
Not at all	2	2	2	4
The increased availability of health insurance provided by employers				
Very much	26	38	34	26
Somewhat	52	50	49	44
Not very much	18	11	14	19
Not at all	3	1	3	6
Patients being hospitalized for minor ailments that can be treated without hospitalization				
Very much	18	15	25	42
Somewhat	38	46	39	35
Not very much	35	32	31	16
Not at all	7	7	5	4
People staying in hospitals longer than necessary				
Very much	9	6	8	32
Somewhat	38	47	46	34
Not very much	42	43	42	24
Not at all	10	4	4	7

(Continued)

Table 2-2 (Continued)

**SPECIFIC REASONS FOR THE RISE IN HEALTH CARE SPENDING:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
The lack of competitive pricing among doctors, hospitals, or nursing homes				
Very much	8	4	29	44
Somewhat	39	33	39	33
Not very much	39	42	23	14
Not at all	11	17	8	5
Fraud and abuse by some nursing homes, doctors, and hospitals				
Very much	5	—	6	36
Somewhat	28	24	36	37
Not very much	53	67	51	17
Not at all	9	8	6	3

Note: Those who are "not sure" or responded "refused/no answer" are not shown on this table.

¹Less than 0.5%.

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983.

It should be noted that various subgroups of physicians hold slightly different views on whether or not a lack of competitive pricing among providers has led to the increase in health care spending. As is evident from Table 2-3, AMA members marginally reject the view that a lack of competitive pricing has resulted in increased health care spending, while non-AMA members marginally endorse it. The number of years since graduation appears to be related to opinion on this issue. A larger percentage (55%) of those who graduated recently (five years or less) endorse the idea that a lack of competitive pricing leads to increased spending, than of those who graduated twenty-one or more years ago (43%).

Table 2-3

**HOW MUCH "LACK OF COMPETITIVE PRICING AMONG DOCTORS, HOSPITALS, OR NURSING HOMES" HAS CONTRIBUTED TO INCREASED HEALTH CARE SPENDING:
BY AMA MEMBERSHIP AND YEARS SINCE GRADUATION**

	Total Physicians	AMA Membership		5 or Less	Years Since Graduation		
		Member	Non- member		6-10	11-20	21 or More
Base	500	266	232	73	120	119	175
	%	%	%	%	%	%	%
Very much	8	5	11	10	10	5	7
Somewhat	39	39	40	45	41	39	36
Not very much	39	40	38	37	33	45	38
Not at all	11	14	8	7	13	8	15
Not sure	3	3	3	1	3	2	5

The third-party payment system is viewed by the vast majority of physicians as contributing to increased health care spending. However, although they almost unanimously agree that patients over-utilize health care services when they themselves don't have to pay for those services, only a modest majority (55%) agree that doctors and hospitals will provide care without regard to cost if they know that insurance and not the patient is paying.

A significant minority (37%) of the physicians agree that spending has risen because there is no real competition to keep prices down. This view is held by only 27% of physician leaders, but by 55% of hospital administrators and 76% of the public (Table 2-4).

It appears that the majority of physicians (60%) and physician leaders (73%) believe that they are working within a price-competitive system, while the majority of their patients (76%) believe that they are not. It should be noted, however, that the public is not militantly demanding or encouraging a price-competitive system. Only 16% of the public (as reported in the earlier survey*) have ever chosen a physician because his or her fees were lower than those of another doctor.

*The Equitable Healthcare Survey: Options for Controlling Costs, Louis Harris and Associates, August 1983

Table 2-4

**UNDERLYING CAUSES OF THE INCREASE IN HEALTH CARE SPENDING:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. Now, I will read you some statements about some causes for the increase in health care spending and some possible solutions. Please tell me, for each one, if you agree with it or disagree with it.

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
If most patients don't have to pay for hospital care, they will want the best care available, no matter how expensive it is				
Agree	89	92	85	84
Disagree	10	8	15	15
Not sure	2	—	—	1
People would use fewer health care services if they personally had to pay a greater share of the cost				
Agree	94	96	92	78
Disagree	5	3	6	20
Not sure	1	1	2	1
One of the problems with health care is that there is no real competition to keep prices down				
Agree	37	27	55	76
Disagree	60	73	42	21
Not sure	3	—	3	2
If doctors and hospitals know that insurance and not the patient is paying, they will provide care without regard to cost				
Agree	55	53	63	74
Disagree	42	46	36	24
Not sure	3	1	1	2

Note: Those "not sure" or for whom item was "not applicable" are not shown on this table.

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983

A great deal has been written about the concentration of health care spending that is attributable to a relatively small proportion of the population. This concentration reflects both the high cost of treating major medical cases and the heavy expenditure on patients in the last year of their lives. However, there is rather widespread disagreement among physicians as to the proportion of all health care costs that are incurred by the highest spending 10% of the population. The median response was that 56% of all spending can be attributed to this 10% of the population (Table 2-5).

The available evidence suggests that this is probably an underestimate. A study of the Federal Employee Benefit Program, conducted by the Congressional Budget Office in 1978, reported that 10% of the families covered accounted for 67% of total expenditures. The Health Care Financing Administration reported that in 1978, 8.8% of the elderly enrolled in Medicare accounted for 70.3% of Medicare expenditures. However, no comparable figure is available for the total population.

Table 2-5

ESTIMATES BY PHYSICIANS OF THE PERCENTAGE OF HEALTH CARE COSTS INCURRED BY THE HIGHEST SPENDING 10% OF THE POPULATION

- Q. It is clear that some people incur more health care costs than others. What percentage of all health care costs do you think is incurred by the 10% of the population who are the biggest consumers and who incur the highest costs?

	Total Physicians
Base	500
	%
Less than 30%	10
30%-39%	13
40%-49%	14
50%-59%	19
60%-75%	17
More than 75%	9
Not sure	17
Refused/no answer	1
Median percentage	56

As is evident from Table 2-6, physicians differ with respect to which factor contributes most to the increased concentration of health care spending. The two reasons cited by over one-fourth of the group are the aging of the population and the use of expensive procedures to save or prolong life. The use of new medical technology is mentioned by 12% of the physicians and unhealthy lifestyles is mentioned by 14%. Only 9% of the physicians believe that overutilization of health care services contributes to a concentration of spending.

Table 2-6

REASONS GIVEN BY PHYSICIANS FOR THE INCREASED CONCENTRATION OF HEALTH CARE SPENDING

- Q. The evidence is that the concentration of health care costs is growing. In other words, the 10% who incur the highest costs are consuming a higher and higher proportion of all costs. Which one of the following do you think contributes most to the increased concentration of health care spending?

	Total Physicians
Base	500
	%
Aging of the population	31
Use of expensive procedures to save or prolong life	27
New medical technology	12
Unhealthy lifestyles	14
Overuse and abuse of health care services by a few people	9
More insurance coverage	4
None of these (vol.)	1
Not sure	3

CHAPTER 3: REACTIONS TO PROPOSED COST- CONTAINMENT CHANGES IN HEALTH CARE SERVICES AND COVERAGE

Introduction

In this chapter the focus of the discussion moves from the general to the specific. Physicians were taken through a list of twenty-three cost-containment policy proposals, all of which have the intention of reducing either nonessential utilization, or health care costs, or both.

Some of these policies relate to employer-provided health care plans, some to government policies and programs, and some to both the public and the private sector.

Most of these policies are not entirely new. Indeed, many of them are already being applied, at least in a limited way, by some employers and insurance plans or in parts of the public sector. Almost all of them require sacrifices of some kind by patients or providers. Some involve increased cost-sharing by consumers or reduced freedom to choose health care providers; others involve alternatives to the traditional fee-for-service payment system.

For this reason, the questions in this survey did not ask physicians what policies they would ideally like to have, but rather what they would be willing to accept in the interest of controlling health care costs and spending.

The Findings

Responses to these different proposals vary widely from overwhelming acceptance to massive opposition. One general finding, which is true of the majority of proposals, is the relatively high correlation between the perceived effectiveness of a policy and its acceptability to physicians. Where a policy is perceived to be effective, it is generally acceptable. Where it is not acceptable, it is generally not thought to be effective.

Detailed data from the physician survey are presented in Table 3-1, while Table 3-2 provides comparative data on the same items from the earlier survey.*

• Proposed changes in health care coverage designed to reduce nonessential utilization by shifting more out-of-pocket costs to the American public

Large majorities of physicians, like physician leaders and hospital administrators, believe that policies which would increase cost-sharing by patients would be both effective and acceptable. These policies, namely paying part of the insurance premiums, and increased deductibles and copayments, are also acceptable, albeit by much smaller margins, to the American public.

The administration's proposal to tax the top portion of large health insurance premiums is acceptable to only 41% of the physicians, in contrast with 62% of the physician leaders and 51% of the hospital administrators. Not surprisingly, the majority of the American public oppose this proposal which does not provide a personal incentive for decreased utilization of health care services.

• Proposals aimed at keeping hospitalization to a minimum by offering other treatment options

Large majorities of physicians endorse health insurance plans that discourage unnecessary hospitalization. Almost all physicians think that insurance plans that encourage the care and treatment of the chronically ill at home, and plans that encourage people to have tests and minor surgery done in clinics and doctors' offices, would be both effective and acceptable.

Reactions were less supportive of insurance plans which require prior approval by insurance companies for nonemergency hospitalization. While a majority regard such a policy as effective, most also think that it would not be acceptable.

These views essentially parallel those of physician leaders and hospital administrators. The American public differs from the provider groups only in that a modest majority (57%) consider precertification for nonemergency hospitalization acceptable.

*The Equitable Healthcare Survey: Options for Controlling Costs. Louis Harris and Associates, August 1983.

- **Proposals to place constraints on price or use of health care services and on equipment purchases**

Any proposal that places constraints on prices is likely to be met with opposition from physicians, despite their marginal willingness to acknowledge the potential effectiveness of these proposals in slowing down the escalation in health care spending.

The notion of government price controls on doctors' and hospital fees draws the greatest consensus of negative response. Fully 85% of the physicians consider such controls unacceptable, even though about half of the group concede that they would be effective. Government price controls are also unacceptable to large majorities of physician leaders and hospital administrators. The American public, however, would consider these controls acceptable by a margin of 61-36%. This potential public support for government price controls truly underscores the gravity of the problem of health cost inflation.

Physicians find the notion of diagnosis-related group-based fixed fees a little more palatable than government price controls. However, a significant 61% consider this policy unacceptable, even though 58% acknowledge its effectiveness in controlling costs. Physician leaders are similarly opposed to this policy, while majorities of hospital administrators and the public would find it acceptable.

All three provider groups view the proposals regarding second opinions for nonemergency surgery, discouraging duplication of expensive treatments at nearby hospitals, and utilization reviews as generally effective and acceptable. The last proposal—utilization reviews by third-party payers—is acceptable to physicians and physician leaders by very small margins.

- **Proposed changes in insurance plans that provide a lower cost option to patients, usually with some built-in constraints, such as less freedom of choice regarding health care providers and procedures**

Physicians' reactions to these proposals, which essentially outline a variety of alternatives to the traditional fee-for-service system, are generally cool.

Most physicians think that Health Maintenance Organizations (HMO's), where for a monthly fee patients receive all physicals, doctors' visits, and hospitalization, are both ineffective and unacceptable.

Preferred Provider Organizations (PPO's) also tend to be regarded as unacceptable by most physicians, although a modest majority concede that PPO's may be effective in controlling prices. These negative reactions apply to both PPO-type plans which exclude all doctors and hospitals not on authorized lists and those which pay a (smaller) part of the cost of the services of these providers. Again these views are consistent with those of physician leaders and not with those of the public. Hospital administrators find the more liberal of the two proposals acceptable.

Health insurance plans in which a primary care provider selected from a list of doctors provides all basic medical care for a fixed fee and assumes the responsibility for authorizing all additional medical services are believed to be effective by a two-thirds majority of physicians, but considered acceptable by only 52%.

Physicians' attitudes to these alternatives to the fee-for-service system closely parallel those of physician leaders, but deviate significantly from those of hospital administrators and the public. The latter two groups, for the most part, find these alternatives acceptable.

- **Proposals that suggest providing incentives for health maintenance and preventive care**

An overwhelming majority of physicians view insurance plans that offer incentives to people who practice health and safety procedures as both effective and acceptable. A large majority feel similarly about group refunds to employees for expenditures that fall below target.

These views are shared by large majorities of physician leaders, hospital administrators, and the general public.

- **Proposed changes in malpractice and anti-trust laws**

Changes in laws relating to malpractice which would reduce the pressure on doctors to practice defensive medicine are generally thought to be both effective and acceptable as cost-containment measures. Physician leaders and hospital administrators concur with physicians on this issue.

Most (71%) physicians believe that changes in anti-trust laws which would allow third-party payers to join together to negotiate fees with hospitals would be effective in reducing costs, but a somewhat smaller majority (55%) consider this proposal acceptable. Physician leaders are split on this issue, but the proposal is acceptable to hospital administrators by a two-thirds majority.

- **Other proposed policies and changes**

Health care coalitions of businesses and employees are generally regarded as effective and acceptable by most physicians, as well as by most physician leaders and hospital administrators.

While half of the physicians concede that a greater use of nurse practitioners, midwives, and physicians' assistants would be effective in reducing health care spending, a significant minority (43%) are also willing to accept a system that encourages this practice. The majority of physician leaders, however, find this proposal unacceptable, while a modest majority of hospital administrators and the American public consider it acceptable.

Limiting the use of expensive procedures for patients with virtually no hope of recovery — so-called "heroic" medicine — is viewed as an effective cost-containment proposal by 78% of the physicians, but considered acceptable by a much smaller majority (59%). The physicians' view on the acceptability of this proposal parallels that of physician leaders. The opinions of hospital administrators and the American public are evenly split on this issue.

To sum up, it appears that American physicians, as a group, are more willing to accept changes in the health care system than are the heads of state, local, and specialty medical societies. Not surprisingly, the cost-containment proposals that they are least likely to find acceptable are those that would adversely affect their income. However, sizable minorities consider even those proposals acceptable. The only proposal that an overwhelming majority of physicians find unacceptable is government price controls. And yet, slightly over one-third of the physicians consider a DRG-based prospective payment system acceptable.

Table 3-1

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

I will read you a list of policies and programs that have been proposed as ways of controlling the rapid increase in the amount of money spent on health care. For each one, I will ask you two questions:

- Q. Do you think it will be very effective, somewhat effective, not very effective, or not at all effective in *controlling costs or discouraging use* of nonessential services?
- Q. Would it be very acceptable, somewhat acceptable, not very acceptable, or not at all *acceptable to you* as a professional in this field?

**Proposed changes in health care coverage designed to reduce nonessential utilization by shifting more
out-of-pocket costs to the American public**

Base: 500	Very %	Somewhat %	Not Very %	Not at All %
Requiring employees to pay a part of their health insurance premiums				
How effective	25	47	19	8
How acceptable	39	43	11	5
Increasing the deductible—the costs that a patient must pay before the insurance plan starts to cover medical expenses—so that people become more cost-conscious when seeking medical services				
How effective	41	44	10	4
How acceptable	41	34	14	10
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses				
How effective	37	44	14	4
How acceptable	34	37	16	11
Requiring employees whose employers pay large health insurance premiums for them to pay taxes on the portion of the premium that exceeds \$840 for the individual and \$2,100 for the family				
How effective	10	27	30	22
How acceptable	15	26	21	26

(Continued)

Table 3-1 (Continued)

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

Proposals that are aimed at keeping hospitalization to a minimum by offering other treatment options

Base: 500	Very	Somewhat	Not Very	Not at All
	%	%	%	%
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes				
How effective	60	33	4	3
How acceptable	66	27	2	4
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals				
How effective	60	32	5	1
How acceptable	66	27	4	2
A system in which the patient has to obtain from the insurance company payment approval for specific expenses and length of hospitalization prior to nonemergency hospitalization				
How effective	20	40	21	14
How acceptable	14	27	24	33

(Continued)

Table 3-1 (Continued)

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

Proposals to place constraints on price or use of health care services and on equipment purchases

Base: 500	Very	Somewhat	Not Very	Not at All
	%	%	%	%
In the case of nonemergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary				
How effective	17	37	27	19
How acceptable	41	33	10	13
A system that discourages a hospital from having expensive equipment and specialists, if they are available at another hospital nearby				
How effective	32	41	17	9
How acceptable	31	34	17	16
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures				
How effective	14	47	23	13
How acceptable	18	35	19	25
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed				
How effective	15	43	22	15
How acceptable	9	28	25	36
Government price controls of doctors' and hospital fees				
How effective	17	32	18	30
How acceptable	3	10	15	69

(Continued)

Table 3-1 (Continued)

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

Proposed changes in insurance plans that provide a lower cost option to patients, usually with some built-in constraints, such as less freedom of choice regarding health care providers and procedures

Base: 500	Very	Somewhat	Not Very	Not at All
	%	%	%	%
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient				
How effective	19	49	20	11
How acceptable	15	37	19	28
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list				
How effective	12	50	23	13
How acceptable	11	30	27	31
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services				
How effective	12	27	28	30
How acceptable	13	27	18	40
Including only hospitals and doctors with lower prices in a health insurance plan, and excluding those that are more expensive				
How effective	12	40	29	15
How acceptable	8	26	24	39

(Continued)

Table 3-1 (Continued)

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

Proposals that suggest providing incentives for health maintenance and preventive care

Base: 500	Very %	Somewhat %	Not Very %	Not at All %
Insurance plans that offer incentives to people who practice health and safety procedures—such as nonsmokers, seatbelt users, or those who are not overweight				
How effective	46	37	12	3
How acceptable	80	15	3	2
Insurance plans that give refunds to be shared among all employees when their total health care expenditures fall below target				
How effective	27	50	16	5
How acceptable	49	37	5	6

Proposed changes in malpractice and antitrust laws

Base: 500	Very %	Somewhat %	Not Very %	Not at All %
Changing laws that seem to encourage doctors to order tests and procedures just to protect themselves from malpractice suits				
How effective	40	39	8	9
How acceptable	55	23	6	13
Changing antitrust laws to allow third-party payers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders				
How effective	18	53	14	9
How acceptable	16	39	16	23

(Continued)

Table 3-1 (Continued)

**ANTICIPATED EFFECTIVENESS AND ACCEPTABILITY OF PROPOSED COST-CONTAINMENT
POLICIES AND PROGRAMS: BY PHYSICIANS**

Other policies

Base: 500	Very %	Somewhat %	Not Very %	Not at All %
Businesses and employers in particular cities or areas working together in health care coalitions to reduce costs				
How effective	22	57	11	5
How acceptable	33	46	7	9
Limiting the use of expensive medical technology for patients who have virtually no hope of recovery				
How effective	39	39	12	7
How acceptable	30	29	14	23
A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians				
How effective	8	42	29	17
How acceptable	11	32	22	32

Note: Those who are "not sure" or responded "refused/no answer" are not shown on this table.

Table 3-2

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

I will read you a list of policies and programs that have been proposed as ways of controlling the rapid increase in the amount of money spent on health care.

Q. Would it be very acceptable, somewhat acceptable, not very acceptable, or not at all *acceptable to you* as a professional in this field?

**Proposed changes in health care coverage designed to reduce nonessential utilization by shifting more
out-of-pocket costs to the American public**

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Requiring employees to pay a part of their health insurance premiums				
Very/somewhat acceptable	82	89	81	65
Not very/not at all acceptable	16	10	18	32
Increasing the deductible—the costs that a patient must pay before the insurance plan starts to cover medical expenses—so that people become more cost-conscious when seeking medical services				
Very/somewhat acceptable	75	89	79	58
Not very/not at all acceptable	24	10	20	39
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses				
Very/somewhat acceptable	71	82	76	52
Not very/not at all acceptable	27	17	22	46
Requiring employees whose employers pay large health insurance premiums for them to pay taxes on the portion of the premium that exceeds \$840 for the individual and \$2,100 for the family				
Very/somewhat acceptable	41	62	51	39
Not very/not at all acceptable	47	36	43	56

(Continued)

Table 3-2 (Continued)

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Proposals that are aimed at keeping hospitalization to a minimum by offering other treatment options

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Insurance plans that encourage the care and treatment of the chronically ill at home instead of in hospitals and nursing homes				
Very/somewhat acceptable	93	91	91	78
Not very/not at all acceptable	6	7	8	20
A system that encourages people to have tests and minor surgery done in clinics and doctors' offices rather than in hospitals				
Very/somewhat acceptable	93	99	84	83
Not very/not at all acceptable	6	1	13	16
A system in which the patient has to obtain from the insurance company payment approval for specific expenses and length of hospitalization prior to nonemergency hospitalization				
Very/somewhat acceptable	41	34	47	57
Not very/not at all acceptable	57	66	51	41

(Continued)

Table 3-2 (Continued)

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Proposals to place constraints on price or use of health care services and on equipment purchases

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
In the case of nonemergency surgery, requiring the patient to get a second opinion from another doctor to find out if the surgery is necessary				
Very/somewhat acceptable	74	63	84	88
Not very/not at all acceptable	23	37	15	10
A system that discourages a hospital from having expensive equipment and specialists, if they are available at another hospital nearby				
Very/somewhat acceptable	65	51	73	62
Not very/not at all acceptable	33	47	25	36
Utilization reviews conducted by third-party payers to discourage the use of expensive and/or inessential procedures				
Very/somewhat acceptable	53	52	66	x
Not very/not at all acceptable	44	47	33	x
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed				
Very/somewhat acceptable	37	32	71	76
Not very/not at all acceptable	61	67	27	21
Government price controls of doctors' and hospital fees				
Very/somewhat acceptable	13	7	21	61
Not very/not at all acceptable	85	90	74	36

(Continued)

Table 3-2 (Continued)

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Proposed changes in insurance plans that provide a lower cost option to patients, usually with some built-in constraints, such as less freedom of choice regarding health care providers and procedures

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Health insurance in which a patient selects a physician from a list of doctors who provide all basic medical care for a predetermined fee, and who also assume the responsibility for authorizing all services from specialists, labs, and hospitals for that patient				
Very/somewhat acceptable	52	48	80	69
Not very/not at all acceptable	47	52	19	29
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list				
Very/somewhat acceptable	41	41	68	61
Not very/not at all acceptable	58	58	32	36
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services				
Very/somewhat acceptable	40	37	66	61
Not very/not at all acceptable	58	61	33	36
Including only hospitals and doctors with lower prices in a health insurance plan, and excluding those that are more expensive				
Very/somewhat acceptable	34	31	45	62
Not very/not at all acceptable	63	68	53	34

(Continued)

Table 3-2 (Continued)

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Proposals that suggest providing incentives for health maintenance and preventive care

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Insurance plans that offer incentives to people who practice health and safety procedures—such as nonsmokers, seatbelt users, or those who are not overweight				
Very/somewhat acceptable	95	97	92	80
Not very/not at all acceptable	5	2	7	18
Insurance plans that give refunds to be shared among all employees when their total health care expenditures fall below target				
Very/somewhat acceptable	86	89	88	x
Not very/not at all acceptable	11	10	10	x

Proposed changes in malpractice and antitrust laws

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Changing laws that seem to encourage doctors to order tests and procedures just to protect themselves from malpractice suits				
Very/somewhat acceptable	78	86	77	x
Not very/not at all acceptable	19	12	20	x
Changing antitrust laws to allow third-party payers to join together to negotiate with hospitals to cut costs and seek lower charges for their policyholders				
Very/somewhat acceptable	55	47	69	x
Not very/not at all acceptable	39	52	27	x

(Continued)

Table 3-2 (Continued)

**ACCEPTABILITY OF PROPOSED COST-CONTAINMENT POLICIES AND PROGRAMS:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Other policies

	Physicians	Physician Leaders¹	Hospital Administrators¹	Public¹
Base	500	100	100	1501
	%	%	%	%
Businesses and employers in particular cities or areas working together in health care coalitions to reduce costs				
Very/somewhat acceptable	79	85	87	x
Not very/not at all acceptable	16	15	12	x
Limiting the use of expensive medical technology for patients who have virtually no hope of recovery				
Very/somewhat acceptable	59	59	48	49
Not very/not at all acceptable	37	38	49	46
A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians				
Very/somewhat acceptable	43	24	59	63
Not very/not at all acceptable	54	75	40	35

Note: Those who are "not sure" or responded "refused/no answer" are not shown on this table.

x = Item not asked of these respondents

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983.

There are some differences in the attitudes of physicians from different geographic regions towards cost-containment proposals which have a direct or indirect impact on their income (Table 3-3). These differences are as follows:

- The HMO-type prepaid plan finds lower acceptability in the South and West, as compared to the East and Midwest.
- The regional differences in attitudes toward the use of nurse practitioners, midwives, and physicians' assistants instead of physicians are marginal, being unacceptable to slightly more physicians in the South and West.
- Physicians in the South show a greater consensus regarding the unacceptability of preferred provider plans than do physicians in the other regions.
- A system with fixed diagnosis-related fees applying to all providers is also unacceptable to a larger majority of physicians in the South than in any other region.
- While government price controls are unacceptable to very large majorities in all regions, they are unacceptable to virtually all physicians in the South.

There are minor differences of opinion regarding the above five proposals among physicians who graduated from medical school at different points in time. It is, however, interesting to note that the HMO-type prepaid plan finds greater acceptability among younger physicians than among older physicians. Although this finding is not surprising, it is important to note that among physicians who graduated less than six years ago, a marginal majority (51%) consider the HMO-type plan acceptable.

An interesting difference is evident in the attitudes of younger versus older physicians towards proposals for increased cost-sharing by patients. Older physicians tend to endorse these proposals in larger numbers than younger physicians (Table 3-4).

Table 3-3

**ACCEPTABILITY OF POLICIES WHICH HAVE A DIRECT OR INDIRECT IMPACT
ON PHYSICIANS' INCOMES: BY REGION AND YEARS SINCE GRADUATION**

I will read you a list of policies and programs that have been proposed as ways of controlling the rapid increase in the amount of money spent on health care.

Q. Would it be very acceptable, somewhat acceptable, not very acceptable, or not at all *acceptable to you* as a professional in this field?

	Total Physicians	Region				Years Since Graduation			
		East	Mid- west	South	West	5 or Less	6-10	11-20	21 or More
Base	500	150	112	128	110	73	120	119	175
	%	%	%	%	%	%	%	%	%
A system that encourages the use of nurse practitioners, midwives, and physicians' assistants rather than physicians									
Very/somewhat acceptable	43	46	46	41	39	44	42	40	45
Not very/not at all acceptable	54	51	51	56	58	54	55	58	53
Health insurance in which patients who use physicians and hospitals selected by the plan pay a lower share of the cost of services than patients who choose doctors and hospitals not on the list									
Very/somewhat acceptable	41	41	47	31	44	41	42	42	39
Not very/not at all acceptable	58	57	52	66	56	57	59	58	59
A health plan where, for a monthly fee paid in advance, you receive physicals, doctors' visits, and hospitalization no matter how often you use these services									
Very/somewhat acceptable	40	46	44	32	35	51	45	39	30
Not very/not at all acceptable	58	52	55	63	63	48	53	58	67
A system in which the fees paid to doctors and hospitals for treating all patients with particular types of diagnoses are fixed									
Very/somewhat acceptable	37	42	38	29	37	34	34	39	38
Not very/not at all acceptable	61	56	61	68	60	63	66	60	58
Government price controls of doctors' and hospital fees									
Very/somewhat acceptable	13	19	12	5	14	15	15	11	11
Not very/not at all acceptable	85	81	87	92	84	82	85	89	86

Table 3-4

**ACCEPTABILITY OF PROPOSED CHANGES IN HEALTH CARE COVERAGE DESIGNED TO
REDUCE NONESSENTIAL UTILIZATION BY SHIFTING MORE OUT-OF-POCKET COST TO
THE AMERICAN PUBLIC: PHYSICIANS BY YEARS SINCE GRADUATION**

I will read you a list of policies and programs that have been proposed as ways of controlling the rapid increase in the amount of money spent on health care.

Q. Would it be very acceptable, somewhat acceptable, not very acceptable, or not at all *acceptable to you* as a professional in this field?

	Total Physicians	Years Since Graduation			
		5 or Less	6 to 10	11 to 20	21 or More
Base	500	73	12	119	175
	%	%	%	%	%
Requiring employees to pay part of their health insurance premiums					
Very/somewhat acceptable	82	75	79	90	82
Not very/not at all acceptable	16	24	18	8	14
Increasing the deductible— the costs that a patient must pay before the insurance plan starts to cover medical expenses—so that people become more cost-conscious when seeking medical services					
Very/somewhat acceptable	75	72	68	76	81
Not very/not at all acceptable	24	26	31	24	17
Requiring patients to pay a greater part than they now pay of all their medical bills covered by their health insurance to encourage them to watch their medical expenses					
Very/somewhat acceptable	71	64	66	73	78
Not very/not at all acceptable	27	35	33	25	20
Requiring employees whose employers pay large health insurance premiums for them to pay taxes on the portion of the premium that exceeds \$840 for the individual and \$2,100 for the family					
Very/somewhat acceptable	41	46	39	37	43
Not very/not at all acceptable	47	50	52	50	41

In practice, many employers and insurers do not introduce changes to their health care plans one at a time. It is common practice to combine reductions in benefits with some additional benefits in order to make the reductions more acceptable to employees. This is particularly common where changes in health plans involve sizable increases in deductibles, or copayments, or both.

In this survey physicians were asked about five types of changes to health care plans which involve some trade-offs between reduced benefits and additional benefits. Such changes are thought to be fair and reasonable by large majorities of physicians. The types of changes which are thought to be fair and reasonable are:

- Plans which provide better coverage for tests conducted outside hospitals than for those involving overnight hospitalization;
- Plans which require higher deductibles and copayments for the initial cost of health care, but which provide better coverage for the cost of longer-term care;
- Plans which require patients to pay a larger share of the cost of using hospital emergency rooms, but which provide better coverage for treatment at doctors' offices;
- Plans which require patients to pay a larger share of the cost of overnight hospitalization, but which provide better coverage for ambulatory surgery; and
- Plans which require higher deductibles and copayments, but which include additional dental and vision benefits. It should be noted, however, that about one-third of the physicians do not consider this trade-off fair and reasonable.

Physicians' views on these trade-offs are very similar to those of physician leaders and hospital administrators. One noteworthy finding is that while large majorities of all three groups find the trade-off involving better coverage for longer-term treatment fair, the opinion of the physician leaders is almost unanimous on this point. With the exception of the trade-off involving the addition of dental and vision benefits to a health care plan, all three provider groups consider the trade-offs to be fair by larger majorities than does the American public. The public considers this last trade-off fair and reasonable by a slightly larger margin than do the provider groups (Table 3-5).

Table 3-5

**TRADE-OFFS IN HEALTH CARE COVERAGE CONSIDERED FAIR AND REASONABLE:
PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. I will read you some proposed changes in health insurance plans that involve a trade-off between better coverage for some health care services and higher cost to the patient for others. For each one, please tell me if you think the trade-off is fair and reasonable.

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Providing better coverage for tests conducted without hospitalization than for tests involving overnight hospitalization				
Yes, is fair and reasonable	85	87	77	67
No, isn't fair and reasonable	13	12	21	28
Requiring a patient to pay a larger share of the cost of care obtained at hospital emergency rooms, but with better coverage for treatment at the doctor's office				
Yes, is fair and reasonable	82	83	72	52
No, isn't fair and reasonable	13	14	26	44
Requiring higher deductibles and copayments for the initial cost of health care, but with better coverage for the cost of longer-term treatment				
Yes, is fair and reasonable	81	96	84	61
No, isn't fair and reasonable	15	2	14	34
Requiring patients to pay a larger share of the cost of overnight hospital stays, but providing better coverage for surgery that does not involve hospitalization				
Yes, is fair and reasonable	71	80	76	51
No, isn't fair and reasonable	23	17	23	44
Requiring higher deductibles and copayments, but adding dental and vision benefits in the health care plan				
Yes, is fair and reasonable	57	55	60	65
No, isn't fair and reasonable	34	43	36	30

Note: Those "not sure" are not shown on this table.

¹Source: The Equitable Healthcare Survey: Options for Controlling Costs, Louis Harris and Associates, August 1983.

CHAPTER 4: **OPINIONS ON COST-SHIFTING AND** **HEALTH CARE COVERAGE FOR THE** **UNEMPLOYED**

There is overwhelming disapproval among physicians, as well as the other provider groups, of the concept of cost-shifting. The American public also disapproves of doctors and hospitals being paid less for Medicare and Medicaid patients if it results in higher fees for everyone else. However, a noteworthy minority (22%,) approves of cost-shifting (Table 4-1).

Table 4-1

ATTITUDES TOWARD MEDICARE AND MEDICAID COST-SHIFTING: **PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. Current and proposed government regulations limit the amount the government will pay hospitals and doctors for Medicare and Medicaid patients. Some doctors and hospitals, therefore, are paid less for Medicare and Medicaid patients, and charge higher fees for patients who pay their own bills or are covered by private insurance.

Do you approve or not approve of the government paying lower fees for Medicare and Medicaid patients if it results in higher fees for everyone else?

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Approve	9	5	7	22
Do not approve	87	95	87	74
Not sure/no opinion/no answer	4	—	5	4

¹Source: **The Equitable Healthcare Survey: Options for Controlling Costs**, Louis Harris and Associates, August 1983.

The attitudes of physicians to policies designed to provide the unemployed better access to health care vary widely from policy to policy. The two policies favored by the majority of physicians (62% and 69%, respectively) are: requiring employers, by law, to maintain health insurance benefits for six months past termination of employment; and encouraging each state to provide health care coverage for its unemployed workers.

Policies to finance coverage for the unemployed not favored by the majority of physicians are: new taxes on individuals' employer-paid health insurance premiums; establishment of a federal program similar to Medicare; and new taxes on third-party payers (Table 4-2).

Table 4-2

PHYSICIANS' ATTITUDES TOWARD HEALTH CARE COVERAGE FOR THE UNEMPLOYED

Q. One group that is largely not covered by health insurance is the unemployed. Several proposals have been made to ensure that this group gets some type of health care coverage. For each proposal I read to you, please tell me whether or not you favor it.

	Total Physicians
Base	500
	%
Encouraging but not requiring each state to pay for health care coverage for unemployed workers	
Favor	69
Do not favor	28
Not sure/no opinion	3
Requiring employers, by law, to maintain health insurance benefits for laid-off workers for six months and contribute to a pool of funds to provide another twelve months of coverage	
Favor	62
Do not favor	34
Not sure/no opinion	3
Financing health care coverage for the unemployed by establishing a federal government program similar to the Medicare program	
Favor	43
Do not favor	54
Not sure/no opinion	3
Establishing a tax on third-party payers to finance extension of benefits for the unemployed	
Favor	34
Do not favor	62
Not sure/no opinion	4
Financing health care coverage for the unemployed from new taxes on individuals' employer-paid health insurance premiums that exceed a set amount	
Favor	31
Do not favor	65
Not sure/no opinion	4

Overall, physicians favor providing health care coverage for unemployed workers and their families, even if it means a direct or indirect increase in the cost of health care to other people. It is not surprising that while a majority in the provider groups favor health care coverage for the unemployed despite cost to others, a modest majority of the American public do not (Table 4-3).

Table 4-3

**ATTITUDES TOWARD HEALTH CARE COVERAGE FOR THE UNEMPLOYED
DESPITE COST TO OTHERS: PHYSICIANS, PUBLIC, AND OTHER GROUPS COMPARED**

Q. Do you favor providing health care coverage for unemployed workers and their families *even if* it means that the cost to other people will increase directly or indirectly through higher medical or insurance bills or increased taxes?

	Physicians	Physician Leaders ¹	Hospital Administrators ¹	Public ¹
Base	500	100	100	1501
	%	%	%	%
Yes, favor	61	67	58	43
No, do not favor	33	28	38	53
Not sure/no opinion	6	4	4	3

¹Source: *The Equitable Healthcare Survey: Options for Controlling Costs*, Louis Harris and Associates, August 1983

APPENDIX A: SURVEY METHOD

The methodology used in this survey parallels that for the health care cost-containment survey conducted in 1983. The reader is referred to the report entitled **The Equitable Healthcare Survey: Options for Controlling Costs** for details on the research procedures used in the earlier study.

Procedures used in this study are detailed below.

The Sample

A total of 500 interviews were conducted with a national cross section of practicing physicians. A list of 2,500 names was obtained from the American Medical Association and the sample was drawn systematically (one name from a cluster of five names) with regional controls.

Interviewing

All interviews were conducted by telephone from the New York offices of the National Center for Telephone Research, the division of Louis Harris and Associates which conducts all the firm's telephone interviews. All interviews were subject to careful monitoring and supervision. Interviews were conducted from January 9, 1984 through February 14, 1984.

Data Processing

The editing, coding, and data processing of all questionnaires were conducted by Louis Harris and Associates. Codes developed for responses to open end questions from the earlier survey were used in this study to ensure comparability of the data.

Weighting of the Data

The data reported on the sample of 500 physicians are not weighted. Comparison data on physician leaders and hospital administrators from the earlier study are also unweighted. The data from the public sample were weighted to be representative of the population of U.S. households. The weights were based on the 1980 census counts for age, race, sex, and income.

APPENDIX B: PROFILE OF THE PHYSICIAN SAMPLE

	Unweighted Percentage in Sample
Base	500
	%
AMA Membership	
Members	53
Nonmembers	46
Years Since Graduation	
Five years or less	15
Six to ten years	24
Eleven to twenty years	24
Twenty-one or more years	35
Type of Employment	
Self-employed (only)	66
Salaried employee (only)	30
Both self-employed and salaried	4
Primary Specialty	
Allergy	1
Anesthesiology	5
Cardiovascular Disease/Cardiology	3
Dermatology	1
Diagnostic Roentgenology	*
Emergency Medicine	3
Endocrinology	*
Family Practice	13
Gastroenterology	1
General Practice	4
Internal Medicine (General)	12
Nephrology	*
Neurology	1
Obstetrics and Gynecology	10
Oncology	1
Ophthalmology	3
Otorhinolaryngology/ENT	1
Pathology	3
Pediatrics	7
Psychiatry	9
Pulmonary Diseases	*
Radiology/Therapeutic Radiology	8
Cardiovascular Surgery	1
General Surgery	5
Head and Neck Surgery	*
Neurological Surgery	1
Orthopedic Surgery	3
Plastic Surgery	*
Thoracic Surgery	*
Urological Surgery/Urology	2
Other	3

*Less than 0.5%

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The Equitable Healthcare Survey III:

CORPORATE INITIATIVES & EMPLOYEE ATTITUDES ON COST CONTAINMENT

Conducted for The Equitable Life Assurance Society of the United States

February and March 1985

Project Directors:

Humphrey Taylor, President, Louis Harris and Associates, Inc.
Stuart Leichenko, Research Associate

FOREWORD

The rising cost of health care continues to be among the most serious problems facing this nation. As one of the country's largest health insurers, The Equitable, of course, has a crucial stake in controlling these costs.

We strongly believe that corporations can and should play a major role in controlling their own health care costs. This survey, the third in a series of major health care research projects sponsored by The Equitable, underlines the importance and the impact of the employer in controlling health care cost inflation:

This survey helps to shed more light on what private sector employers are doing to control their health costs, and, for the first time, measures the success

of their efforts. It also provides important insight into the attitudes of employees towards the changes that have been made in their health benefit plans.

The Equitable is pleased to make this information available as a public service. This report is another important tool for benefit planners to use in designing effective cost controls in the future. We hope that it will be used in formulating plans and implementing successful health care cost containment policies.

Gilbert M. Reich
Executive Vice President
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INTRODUCTION

The principal purpose of this survey is to provide corporate decisionmakers with guidelines for action in shaping their health care plans over the next few years. The survey documents in detail what has happened over the last several years, so that corporate employers can draw on these experiences and take advantage of the lessons that have been learned.

This is a detailed study of many cost containment initiatives which have been taken, showing what companies have or have not done, and how successful or unsuccessful their efforts have been. The Equitable Healthcare Survey III is not only the first comprehensive picture of how corporations are faring in their efforts to contain employee health care costs, but also the first survey to report how employees are reacting to changes in their health care benefits, how acceptable they find these changes, and how their use of health care services has been affected.

The Equitable Healthcare Survey III is the third survey conducted by Louis Harris and Associates on health care cost containment for The Equitable Life Assurance Society. In the Summer of 1983, Harris conducted **The Equitable Healthcare Survey: Options for Controlling Costs**, which provided a detailed assessment of the attitudes of the American public, employers, unions, hospital administrators, health insurance executives, and the elected leaders of physicians' organizations to a wide range of health care cost containment policies. Early in 1984, Harris conducted **The Equitable Healthcare Survey II: Physicians' Attitudes Toward Cost Containment**, which surveyed the views of a national cross section of physicians on the same issues.

This third survey is designed to build upon the first two studies and to measure the effect of many of the changes which they discussed.

Interviews for this third survey were conducted in February and March 1985 with the following samples, all of which are designed to be representative of the populations from which they are drawn:

- A national cross section of 1,253 employees in corporations with 500 or more employees.
- A national cross section of 1,250 corporate benefits officers in companies with 500 or more employees.
- A national cross section of 200 senior executives in companies with 500 or more employees.
- A national cross section of 200 senior human resource executives in companies with 500 or more employees.
- One hundred and ten national and regional insurance brokers and consultants who work with corporate clients in the field of group health plans.

Details and design of the study and of the methods used to conduct the survey are given in the Appendix.

Note on the Tables

Percentages in the tables may not add to 100% because of rounding or the acceptance of multiple responses.

Acknowledgments

Louis Harris and Associates is indebted to The Equitable Life Assurance Society of the United States for making this research possible. The contribution of the following individuals at Equitable is gratefully acknowledged: Richard Freiburger, James Glynn, Arthur Lifson, and Linda Gall. Each of these individuals made important contributions to the design of the study and the development of the questionnaire.

Final responsibility for the design and implementation of the survey and for the findings and conclusions contained in this report rests with Louis Harris and Associates.

SURVEY HIGHLIGHTS

This summary provides an overview of the results of this survey. There are, of course, many findings described in the body of the report which are not summarized here, and interested readers are urged to examine the full report for these details.

1. **Corporations have made a great many changes to their health care plans in order to contain costs.** More than 70% of employers report that they have changed their health care plans a great deal or somewhat over the last 3 years. A majority of employers report that these changes have resulted in increased cost-sharing by their employees through contributions to premiums, increased deductibles, or co-payments. A wide variety of other changes have also been made.
2. **The changes made most frequently by corporations over the last 3 years are** the use of second opinions (54%), increasing deductibles (50%), new program features designed to reduce unnecessary hospitalization (47%), and offering employees an HMO option (34%).
3. **These changes have already had a substantial impact on health care costs.** Employers estimate that their 1985 health care costs per employee will be between 16-18% lower as a result of the changes made over the last 3 years. Overwhelming majorities of employers, brokers and consultants rate the changes made as very or somewhat effective.
4. **Successful health care cost containment programs include a variety of different mechanisms.** There is no single element which is a panacea. Nor is there any consensus among employers as to which one element is most important, although between 17-21% of the employer groups identify increased deductibles as the most effective.
5. **Most of the changes made by employers are acceptable to a large majority of employees.** Fully 79% of employees rate the changes made by their employers in the last 3 years as acceptable. And 53% of employees whose cost-sharing has increased over the last 3 years say that this increase was acceptable. When asked

about 17 different types of plan changes, majorities of employees report that all except one (increased co-payments) of these changes are acceptable, even where they have been directly affected by these changes.

Furthermore, the great majority of employers who have increased employee cost-sharing in their plans say that they found it easier than they had anticipated to get employee acceptance of changes. And most employees affected by increased cost-sharing think that it was necessary for their employers to make changes in their health care plans in order to get costs under control.

6. **Some cost control mechanisms appear to be seen by employees as additional benefits.** These include incentives to have tests and minor surgery done outside hospitals, second opinions, the availability of HMO and PPO options, wellness programs, financial incentives to practice good health and safety behaviors, employee health advisory services, medical case management programs, disability case management programs, and flexible plans which offer a choice between different health plans.
7. **While a majority of employees are generally willing to accept some additional cost-sharing, it is not, of course, accepted with any enthusiasm, and attitudes toward additional cost-sharing vary widely.** While most employees think that it is acceptable to pay a contribution to their insurance premiums, only very slender majorities think it is acceptable to increase their deductibles or have co-payments. Only 48% of employees say that it is acceptable to increase their co-payments.
Obviously, increased cost-sharing is not what employees want. The important finding is that most employees are willing to go along with it if the increase is not too large.
8. **Union members are more resistant to change, and to increased cost-sharing, than are non-union employees.** However, the differences are not very large.

- 9 **Low income employees, particularly those earning less than \$15,000 a year, are much more adversely affected by increased cost-sharing and find such changes less acceptable than do other employees.**
- 10 **In winning the acceptance of employees to change the design of corporate health care plans, communications seem to be almost as important as the details of the changes made.** The quality of communications appear to vary greatly from company to company, with many employers reporting that they found it difficult to explain the changes to their employees.
- 11 **The inclusion of additional benefits, particularly dental benefits, makes it easier to win employee acceptance for other changes** which involve increased cost-sharing or constraints on the services which may be used.
- 12 **Changes in corporate health plans appear to be having some impact on total health care expenditures.** Changes made so far have not merely shifted costs from employers to employees. In many instances, these changes appear to have had some impact on consumer behavior, thereby helping to reduce total expenditures on health care services.
- 13 **There is no evidence in this survey that changes made have, as yet, significantly reduced employee access to health care services.** However, there is evidence that increased cost-sharing by low-income employees in the future could significantly reduce their access to care.
- 14 **Corporate health care costs are not yet under control.** Only 10% of employers report that their costs are completely under control. They expect their 1985 per employee costs to rise by a mean of 7-8% in 1985.
- 15 **Corporate health plans look set to change at least as much in the next 3 years as they have in the recent past.**
- 16 **There are dangers in generalizing from the overall findings to the individual employer, health plan, or employee.** This report shows a very wide variety of different behaviors, effects, attitudes and reactions. It is important to recognize that, even where a substantial majority give one answer, sizable minorities, often involving many millions of employees, do not agree with the majority.

The following table summarizes the changes made in the last three years, and their effectiveness and acceptability to employees.



HEALTH PLAN CHANGES MADE IN THE LAST 3 YEARS

	Percent of Companies Which Have Made Change	Acceptability to Employees Affected ¹	Perceived Effectiveness ²
	(fr. Table 4-2)	(fr. Table 5-1)	(fr. Table 6-1)
	%	%	%
Changed to a contributory plan	21	68	71
Introduced deductibles	24	59	82
Increased deductibles	50	54	82
Introduced co-payments	22	52	81
Increased co-payments	27	48	78
Introduced plans to discourage hospitalization	47	83	81
Introduced pre-admission review	28	73	73
Introduced second opinions	54	84	73
Instituted utilization reviews	27	N/A	67
Offered HMO option	34	80	49
Introduced a PPO	9	82	51
Started a wellness program	26	97	67
Instituted incentives for health and safety procedures	12	98	58
Started a health advisory service	6	98	49
Started a medical case management program	10	95	46
Offered a choice of two or more health plans	8	92	48
Introduced a disability case management program	12	96	52
Introduced a salary-related deductive program	7	80	39

¹Acceptability: defined as the percent of employees whose employers have made these changes who say this kind of change is very acceptable.

²Effectiveness: defined as the percent of corporate benefits officers who say this kind of change is "very effective" or "somewhat effective."

**CHAPTER 1:
THE CONTEXT FOR COST CONTAINMENT IN
1985**

Employee Attitudes Toward Their Benefits

Most employees in corporations with 500 or more employees, which were the focus for this study, are satisfied with their jobs, their salaries, their benefits and their health plans. However, the level and intensity of their satisfaction vary. While approximately half of these employees are very satisfied with their jobs (53%), their health plans (50%), and their benefits (47%), only one-third (34%) are very satisfied with their salaries.

Observation:

The level of satisfaction with health plans indicates that the steps taken so far by employers to control their health care costs have not, as yet, triggered any substantial backlash among most employees. Furthermore, the relatively high level of satisfaction with health plans as compared with salaries suggests that there is considerable room for many employers to make further changes in their plans.

**Table 1-1
EMPLOYEE SATISFACTION WITH JOB, SALARY,
BENEFITS AND HEALTH PLAN**

Q.: (Employees) All in all, how satisfied would you say you are with your job—very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

Q.: (Employees) All in all, how satisfied would you say you are with your salary—very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

Q.: (Employees) And how satisfied are you with all of your other benefits apart from your salary—very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

Q.: (Employees) And how satisfied are you with the health insurance or health plan provided by your employer—very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

	Job	Salary	Benefits	Health Plan
Base: 1253				
	%	%	%	%
Very satisfied	53	34	47	50
Somewhat satisfied	35	45	35	30
Somewhat dissatisfied	8	13	11	12
Very dissatisfied	4	7	6	7
Not sure	1	*	*	*

*Less than 0.5%.

Although half of all these employees are very satisfied with their health plans and the great majority are very or somewhat satisfied with their plans, the level of satisfaction is significantly lower among employees in plans with higher levels of cost-sharing. Employees with non-contributory plans or plans without deductibles are much more likely to be very satisfied with them than are employees with contributory plans and plans with deductibles.

While the differences between union and non-union employees are relatively small, non-union employees are slightly more likely to be very satisfied with their health benefits than are unionized employees.

Table 1-2

**EMPLOYEE SATISFACTION WITH HEALTH PLAN:
AMONG DIFFERENT GROUPS**

Q.. (Employees) And how satisfied are you with the health insurance or health plan provided by your employer—very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

	All Employees	Union Membership		Type of Plan			
		Member	Nonmember	Contributory	Non- contributory	With Deductible	Without Deductible
Base	1253	288	965	742	497	993	229
	%	%	%	%	%	%	%
Very satisfied	50	46	51	43	59	45	69
Somewhat satisfied	30	33	29	34	25	33	21
Somewhat dissatisfied	12	15	12	14	10	14	6
Very dissatisfied	7	6	8	8	6	9	4
Not sure	*	*	*	1	*	*	*

* Less than 0.5%

How Well Health Care Costs Are Under Control

Most employers think that their corporate health care costs are somewhat under control. Most brokers/consultants confirm this view, believing that most of their corporate clients' costs are somewhat under control.

However, a sizable minority of employers (from 21% of corporate benefits officers to 31% of senior executives) and of brokers/consultants (27%) think that corporate health care costs are still somewhat or totally out of control. And only 10% or less of these groups think that corporate health care costs are completely under control.

Employees' perceptions of their own health care costs are more gloomy. They are more or less equally divided between those who think that their health care costs are under control and those who think they are out of control.

Observation:

It is important to recognize that the answers given by employees refer to their own health care costs, while those of the employers and brokers/consultants refer to corporate health care costs; and that these are not the same thing. Indeed, as employers require their employees to share increasingly in the cost of their health care, the gap between employers' and employees' responses to questions of this kind may widen further.

Table 1-3

HOW WELL HEALTH CARE COSTS ARE UNDER CONTROL

Q. (Employees) In recent years a lot of attention has been on the inflation of health care costs. In general, would you say that the inflation of the health care costs for yourself and your family is completely under control, somewhat under control, somewhat out of control, or totally out of control?

Q. (Employers) Many companies are trying to control their health care costs. In general, would you say that the inflation of your corporate health care costs is completely under control, somewhat under control, somewhat out of control, or totally out of control?

Q. (Brokers/Consultants) First some questions about the health care costs of the companies you work with. In general, would you say that the inflation of their corporate health care costs is completely under control, somewhat under control, somewhat out of control, or totally out of control?

	Employees	Corporate Employers			Brokers/ Consultants
		Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	1253	1250	200	200	110
	98	98	98	98	98
Completely under control	19	10	9	8	3
Somewhat under control	32	68	60	69	70
Somewhat out of control	32	19	28	21	26
Totally out of control	15	2	3	2	1
Not sure	2	1	1	1	-

Estimated Increase in Corporate Health Care Costs in 1985

Employers expect their corporate health care costs per employee to increase by between 7-8%, with senior corporate executives expecting a slightly higher increase than corporate benefits officers or human resource executives.

Brokers and consultants expect a higher (10%) rate of increase in 1985.

Observation:

It should be noted that the companies to which brokers and consultants are referring are not necessarily identical to the employers sampled (i.e., a representative cross-section of corporations of 500 or more employees). It is possible that both the employers and the brokers/consultants are accurate in their perceptions if the latter tend to work with companies with a higher rate of health care cost inflation.

Table 1-4

ESTIMATED (PERCENT) CHANGES IN CORPORATE HEALTH COSTS IN 1985 OVER 1984

Q.: (Employers) How much, in percentage terms, do you think your corporate health cost per employee will change in 1985 as compared with 1984?

Q.: (Brokers/Consultants) How much, in percentage terms, do you think the average corporate health cost per employee of the companies you work with will change in 1985 as compared with 1984?

	Corporate Employers			Brokers/ Consultants
	Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	1250	200	200	110
Estimated mean change	+ 73%	+ 81%	+ 70%	+ 103%

CHAPTER 2: HOW HEALTH PLANS HAVE CHANGED IN THE LAST 3 YEARS

How Much Plans Have Changed

There is general agreement among employees, employers and brokers/consultants that the companies they work for, or with, have changed their health plans a great deal or somewhat over the last three years. However, the magnitude of the change is perceived differently. Over half (52%) of the brokers and consultants report that the companies they work with have changed their plans a great deal. Between 35-41% of the three employer groups (corporate benefits officer, senior executive and human resource executive) report that their companies have changed their plans a great deal. Only

22% of employees report that their health care plans have been changed a great deal.

Observation:

Many changes have been made and most employees and employers are aware of this. The most interesting finding here, however, is that employers and brokers/consultants perceive a greater magnitude of change than do employees. This would suggest that many employees are not all that sensitive to changes in their plans—or at least to the changes that have been made so far—perhaps because only a minority are affected.

Table 2-1

HOW MUCH EMPLOYERS HAVE CHANGED HEALTH PLANS OVER LAST 3 YEARS

Q.: (Employees) How much has your employer changed your health care plan over the last 3 years—a great deal, somewhat, not much, or not at all?

Q.: (Employers) How much would you say that you have changed your health care plans over the last 3 years in order to try to contain health care cost inflation—a great deal, somewhat, not much, or not at all?

Q.: (Brokers/Consultants) How much would you say that most of these companies have changed their health care plans over the last 3 years in order to try to contain health care cost inflation—a great deal, somewhat, not much, or not at all?

	Employees	Corporate Employers			Brokers/ Consultants
		Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	1253	1250	200	200	110
	8%	8%	8%	8%	8%
A great deal	22	41	35*	39	52
Somewhat	37	32	40	37	39
Not much	20	15	18	14	7
Not at all	18	12	7	10	2
Not sure	3	-	2	-	-

*Less than 0.5%

Whether Changes Affected Mainly Union Employees or Non-Union Employees

Overall cost-containment changes in health plans have affected non-union employees more than union members. While half of the employers with unionized employees report that the changes affected both union and non-union employees equally, almost as many reported that these changes mainly affected only their non-union workers.

Table 2-2

WHETHER CHANGES IN HEALTH PLANS MAINLY AFFECTED UNION OR NON-UNION EMPLOYEES

Q: (Corporate Benefits Officers) Are any of your employees union members?

Q: (Corporate Benefits Officers) Did most of the changes you have made to your health plans affect both union and non-union employees, or did they mainly affect only one or the other?

	Corporate Benefits Officers
Base	1250
	%
Employers With Union Employees	40
Affected both equally	20
Affected mainly union employees	1
Affected mainly non-union employees	18
Employers With No Union Employees	60

Estimated Savings in Health Care Costs From Changes that Have Already Been Made

Most employers and the brokers/consultants who advise them believe the changes that have been made in the last three years have already helped them to make significant savings in their health care costs. The three employer groups who report having changed their plans a great deal or somewhat believe that their 1985 health care costs will be between 16% and 18% less than if they had not made any changes over the last three years. Brokers and consultants believe that the savings to the firms they advise average 15%.

Table 2-3

ESTIMATED 1985 SAVINGS IN HEALTH COSTS PER EMPLOYEE RESULTING FROM CHANGES MADE IN LAST 3 YEARS

Q.: (Employers) How much lower, in percentage terms, do you think your 1985 health cost per employee will be than it would have been if you had not made any changes over the last 3 years?

Q.: (Brokers/Consultants) How much lower, in percentage terms, do you think corporate 1985 health cost per employee will be than it would have been if these companies had not made any changes over the last 3 years?

	Corporate Employers			Brokers/ Consultants
	Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	915	149	152	100
Estimated mean savings among companies which changed their plans a great deal or somewhat ¹	17.2%	16.3%	17.9%	15.4%

¹ Based on total number of employers answering this question.

² Base represents total numbers of broker/consultants answering this question.

Effectiveness of Changes

The overwhelming majority of employers rate the changes they have made over the last three years as very or somewhat effective in controlling their health care costs. Only 9% or less of the three employer groups, and only 5% of the brokers/consultants rate these changes not very or not at all effective.

Observation:

It is clear from all of these data that the efforts made by the private sector over the last few years to contain the growth of their health care costs are already paying substantial dividends. However, (as Table 9-4 shows) the great majority of employers believe that they are only at the beginning of the process of containing their health care costs. By no means do they believe that they have yet done all that is necessary.

Table 2-4

EFFECTIVENESS OF CHANGES MADE IN HELPING TO CONTROL HEALTH CARE COSTS

Base: All those whose plans have changed a great deal or somewhat

Q. (Employers) Overall, how effective do you think that the changes you have made are — or will be — in helping you to control your health care costs — very effective, somewhat effective, not very effective, or not at all effective?

Q. (Brokers/Consultants) Overall, how effective do you think that the changes they have made are — or will be — in helping them to control their health care costs — very effective, somewhat effective, not very effective, or not at all effective?

	Corporate Employers			Brokers/ Consultants
	Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	915	149	152	100
	86	96	86	86
Very effective	41	31	37	23
Somewhat effective	52	58	55	70
Not very effective	5	8	5	4
Not at all effective		1		1
Not sure	2	2	3	2

* Less than 0.5%.

Acceptability to Employees of Changes in Health Plans

The great majority of employees (79%) whose plans have changed a great deal or somewhat over the last three years, regard these changes as at least somewhat acceptable. Indeed, one-third (34%) rate them very acceptable. The proportions who rate these changes not very or not at all acceptable are relatively small (16% and 5% respectively).

These views parallel the answers given by employers, who report that the changes that they have made

have been very or somewhat acceptable to most of their employees.

However, reactions by employees vary significantly, depending on who they are, the type of plans they have, and the job done by employers in explaining the changes:

—Non-union employees are somewhat more likely to find the changes very acceptable than are unionized employees (even though the latter appear to have been affected rather less—see Table 2-2)

Table 2-5

ACCEPTABILITY OF CHANGES IN HEALTH PLANS MADE BY EMPLOYERS

Base: All those whose plans have changed a great deal or somewhat

Q.: (Employees) Overall, how acceptable have the changes made by your employer been to employees such as yourself—very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable?

Q.: (Employers) Overall, how acceptable do you think the changes you have made have been to your employees—very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable?

Q.: (Brokers/Consultants) Overall, how acceptable do you think the changes they have made have been to their employees—very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable?

	Employees	Corporate Employers			Brokers/ Consultants
		Corporate Benefits Officers	Senior Executives	Human Resource Executives *	
Base	740	915	149	152	100
	%	%	%	%	%
Very acceptable	34	33	28	28	18
Somewhat acceptable	45	55	60	58	63
Not very acceptable	16	10	11	11	18
Not at all acceptable	5	1	1	1	1
Not sure	1	2	1	2	1

* Less than 0.5%

- Employees who still have non-contributory plans or who pay no deductibles are much more likely to rate the changes made by their employers as very acceptable than are those who have contributory plans or those who pay deductibles.
- Employees who give their employers favorable ratings in explaining the changes are far more likely to find these changes acceptable than are those who give their employers poor ratings for communicating changes.

Observation:

These data, which are paralleled by other findings in the survey, indicate that most employers have been able to make changes in their health plans in order to get costs under control without provoking a substantial backlash from their employees.

They also show, however, that different employees react differently to different changes, and that one cannot generalize from the acceptability of changes in general to the acceptability of all specific changes.

Table 2-6

ACCEPTABILITY OF CHANGES IN HEALTH PLANS MADE BY EMPLOYERS: AMONG DIFFERENT GROUPS OF EMPLOYEES

Base: All employees whose plans have changed a great deal or somewhat

Q. Overall, how acceptable have the changes made by your employer been to employees such as yourself—very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable?

	Base	Very	Somewhat	Not Very	Not at all
All employees	740	34%	45%	16%	5%
By Type of Employee					
Union members	155	25%	54%	14%	7%
Not union members	585	36%	42%	17%	4%
By Type of Plan					
Contributory	468	29%	47%	19%	5%
Non-contributory	265	43%	42%	11%	4%
Deductible	610	31%	46%	19%	5%
No deductible	113	50%	42%	4%	3%
By Job Done by Employer in Explaining Changes					
Excellent	209	60%	31%	8%	1%
Good	275	34%	51%	15%	*
Fair or poor	252	12%	50%	25%	12%

*Less than 0.5%

**CHAPTER 3:
THE EXTENT, ACCEPTABILITY AND EFFECT
OF INCREASED COST-SHARING BY EMPLOYEES**

**How Much Cost-Sharing Has Increased
Over the Last 3 Years**

The magnitude of changes made over the last 3 years, and the extent to which employees have been required to pay a large share of their health care costs, varies widely from company to company and from employee to employee. Only relatively small proportions of companies (15-18% of the different employer groups) and of employees (16%) report that cost-sharing has increased a great deal. The largest numbers report that cost-sharing has increased somewhat or not much.

Sizable minorities (from 19-25%) of the three employer groups and 26% of employees report that there has been no increase in cost-sharing over the last three years.

Observations:

(1) Some employers have clearly been much more aggressive than others in increasing employee cost-sharing through contributions to premiums, deductibles, or co-payments.

(2) It should be noted that these questions were asked after the concepts of contributions, deductibles and co-payments had been explained in considerable detail to employees and employers. (Tables 4-1, 4-2, 5-1 and 6-1 report the responses to the questions in which these concepts were explained.) Interviewers working on this study reported that only a tiny minority of respondents appeared to have any difficulty in understanding these concepts after they had been explained. The low level of "not sure" replies confirms this.

Acceptability of Increased Cost-Sharing to Union and Non-Union Employees

Unionized employees are slightly, but not substantially, more likely to regard increased cost-sharing as unacceptable. This is indicated both by the differences between the replies of union and non-union employees and by the perceptions of their

employers. By 55-44% a majority of non-union employees report that the increased cost to employees is acceptable. By 53-46% a majority of union employees report that the changes are unacceptable

Table 3-1

HOW MUCH COST-SHARING BY EMPLOYEES HAS INCREASED OVER LAST 3 YEARS

Q. (Employees) Comparing your health plan today with your health plan 3 years ago, how much would you say that the amount paid by employees such as yourself—through contributions to premiums, deductibles, or co-payments—has increased—a great deal, somewhat, not much, or not at all?

Q. (Employers) Comparing your health plan today with your health plan 3 years ago, how much would you say cost-sharing by your employees—through contributions to premiums, deductibles, or co-payments—has increased—a great deal, somewhat, not much, or not at all?

Q. (Brokers/Consultants) Comparing the health plans today of most of the companies you work with and their health plans 3 years ago, how much would you say cost-sharing by their employees—through contributions to premiums, deductibles, or co-payments—has increased—a great deal, somewhat, not much, or not at all?

	Employees	Corporate Employers			Brokers/ Consultants
		Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	1253	1250	200	200	110
	98	98	98	98	98
A great deal	16	18	17	15	37
Somewhat	34	34	37	37	44
Not much	23	23	27	23	17
Not at all	26	24	19	25	2
Not sure	2	2	2	1	-

Observation:

These findings and other data in this report indicate it is somewhat more difficult for employers to increase cost-sharing for unionized employees, and that unionized employees are more likely to resist such changes.

Table 3-2

**ACCEPTABILITY TO UNION AND NON-UNION EMPLOYEES
OF MOST RECENT INCREASE IN COST-SHARING**

Base: All employees whose cost-sharing has increased a great deal or somewhat

Q. (Employees) The last time your employer increased the cost to employees, how acceptable was this change to you—very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable?

Q. (Employers) The last time you increased the cost-sharing for union employees, how acceptable do you think this change was to most of those employees—very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable?

Q. (Employers) The last time you increased the cost-sharing for **non-union employees**, how acceptable do you think this change was to most of those employees—very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable?

				In Relation to Union Employees	In Relation to Non-Union Employees		
	All Employees	Union Employees	Non-Union Employees	Corporate Benefits Officers	Corporate Benefits Officers	Senior Executives	Human Resources Executives
Base	624	133	487	136	641	107	104
	%	%	%	%	%	%	%
Very acceptable	10	7	11	9	14	11	18
Somewhat acceptable	43	39	44	43	50	62	47
Not very acceptable	30	35	28	30	27	22	24
Not at all acceptable	16	18	16	9	4	2	4
Not sure	1	2	1	4	4	2	6
Not applicable ^a	NA	NA	NA		1	1	1

^aNA means that the question was not asked.

Note: The sub-sample of senior executives and human resource executives with union employees are not large enough to provide reliable data and, therefore, are not shown here.

Effect of Increased Cost-Sharing on Employee Behavior in the Use of Health Care Services

Two views are frequently expressed about the impact of increased cost-sharing on employees. One view is that increased cost-sharing causes employees to reduce their total health care spending by cutting out some inessential use of medical services, by encouraging them to compare medical fees, and to shop around for cost-effective services. Another view is that increased cost-sharing does not affect behavior, but merely shifts more of the cost of the same services to employees.

This survey appears to confirm both theories. While 41% of employees affected by increased cost-sharing report that this has changed their behavior a great deal or somewhat, 25% say that their behavior has changed not much, and 32% say that it has not changed at all.

Employers and their consultants look at the same issue, not in terms of each and every employee, but in terms of employees in the aggregate. Majorities of employers and consultants report that employee behavior has been affected a great deal or somewhat, which is not inconsistent with the replies given by individual employees.

The impact on employee behavior in the use of health care services is highly correlated with income. A majority of employees earning \$15,000 or less, who have been affected by cost-sharing, report that their behavior has been affected a great deal or somewhat. Only a relatively small proportion (24%) of those earning \$35,000 a year or more report that their behavior has been affected.

Observation:

Increased cost-sharing appears to be at least somewhat successful in reducing not only corporate health care costs, but national health care costs.

Increases in employee cost-sharing as a result of changes in corporate health care plans are, it seems, starting to have some impact on consumer behavior and, therefore, on total health care spending. If this trend grows and continues, and if there are parallel changes in behavior by Medicare and Medicaid recipients, then increased cost-sharing will help to contain the growth of health care costs for the nation as a whole.

However, it should also be noted that increased cost-sharing affects the behavior of low income groups much more than that of middle or high income groups. Those who can afford to spend more money on health care services will do so. Those who cannot afford to do so will either use lower cost health care facilities, or use them less, or both. This finding provides strong support for the idea of salary-related deductibles.

Table 3-3

HOW MUCH INCREASED COST-SHARING HAS CHANGED EMPLOYEE BEHAVIOR IN THE USE OF HEALTH CARE SERVICES

Base: All whose plans have increased employee cost sharing a great deal or somewhat

Q.: (Employees) Some people think that increased cost-sharing by employees reduces their total health care spending by cutting out some inessential use of medical services and by encouraging them to compare medical fees. Other people think that increased cost-sharing merely shifts more of the cost to employees, without changing their behavior. How much do you think increased cost-sharing has changed the way you and your family use health care services in order to save money—a great deal, somewhat, not much, or not at all?

Q.: (Employers) Some people think that increased cost-sharing by employees helps to limit their total health care spending by cutting out some inessential use of medical services and by encouraging them to compare medical fees. Other people think that increased cost-sharing merely shifts more of the cost to employees, without changing their behavior. From what you have seen of **your** employee health costs, how much do you think increased cost-sharing has changed employee behavior and helped to limit total employee health care spending—a great deal, somewhat, not much, or not at all?

Q.: (Brokers/Consultants) Some people think that increased cost-sharing by employees helps to limit their total health care spending by cutting out some inessential use of medical services and by encouraging them to compare medical fees. Other people think that increased cost-sharing merely shifts more of the cost to employees, without changing their behavior. From what you have seen of employee health costs, how much do you think increased cost-sharing has changed employee behavior and helped to limit total employee health care spending—a great deal, somewhat, not much, or not at all?

	Employees	Corporate Employers			Brokers/ Consultants
		Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	624	641	107	104	89
	%	%	%	%	%
A great deal	14	15	13	16	23
Somewhat	27	51	51	53	48
Not much	25	21	24	22	25
Not at all	32	8	9	6	3
Too early to say	*	3	1	3	—
Not sure	1	2	1		1

*Less than 0.5%.

Note: Because of the differences between the questions put to the different samples the responses of the different groups are not exactly comparable.

Table 3-4

**HOW MUCH INCREASED COST-SHARING HAS CHANGED EMPLOYEE BEHAVIOR IN THE USE
OF HEALTH CARE SERVICES: BY INCOME**

Base: All employees whose cost-sharing has increased a great deal or somewhat

Q: (Employees) Some people think that increased cost-sharing by employees reduces their total health care spending by cutting out some inessential use of medical services and by encouraging them to compare medical fees. Other people think that increased cost-sharing merely shifts more of the cost to employees, without changing their behavior. How much do you think increased cost-sharing has changed the way you and your family use health care services in order to save money—a great deal, somewhat, not much, or not at all?

	All Employees	Income From Employers			
		\$15,000 or Less	\$15,001 to \$25,000	\$25,001 to \$35,000	\$35,001 or More
Base	624	184	167	130	126
	%	%	%	%	%
A great deal	14	24	13	10	5
Somewhat	27	28	32	30	19
Not much	25	28	22	25	25
Not at all	32	19	33	33	50
Not sure	1	1	1	2	1

CHAPTER 4: THE USE OF 18 DIFFERENT COST CONTAINMENT MECHANISMS

Table 4-1 shows the number of employees in corporations with 500 or more employees, who report that their plans have, or do not have, different health care cost containment mechanisms.

It is clear from the replies that the use of these different mechanisms by corporate employers varies widely. While most employees report that they pay deductibles and that they contribute to their health insurance premiums, only very small minorities report that their plans include salary-related deductibles or medical case management programs.

Observations:

(1) The replies given by employees in Table 4-1 are a measure of what employees believe their plans include. They are not necessarily completely accurate. The relatively high level of "not sure" responses given to some of the less well known mechanisms is one indication of employee ignorance. Furthermore,

the percentages for some of the claimed features (e.g., DRGs and PPOs) seem improbably high.

(2) A very important finding here is the very large number of employees whose plans do not apparently include the various cost control mechanisms. While most employees are affected by cost-sharing, fully 30% do not pay deductibles, 46% do not pay co-payments, and 40% do not contribute to their insurance premiums.

Furthermore, only relatively small minorities (33% or less) report that their plans include each of the many other elements listed. While minorities of employers appear to be using these cost control mechanisms, most employers are still not doing so.

(3) The fact that employees report that an element is included in their plans does not necessarily mean that they use it. While 32% of these employees are aware of the opportunities to join HMOs, only 7% reported that they were HMO members. While 24% report that they have the opportunities to join a PPO, only 5% report that they have done so.

Table 4-1

**REPORTED PREVALENCE OF DIFFERENT HEALTH
CARE COST CONTROL MECHANISMS**

Base: All employees

Q. (Employees) Many employers have tried to design employee health plans to slow down the inflation of the costs to the company. I will read you a short list of elements of some health care plans designed to contain costs. Would you please tell me for each one if it applies to your health insurance plan, or not?

	Applies	Does Not Apply	Not Sure
Base 1253	%	%	%
A contributory plan in which employees pay part of their health insurance premiums	59	40	1
A deductible paid by employees before the plan starts to cover their medical expenses	68	30	2
Co-payments by employees covering part of each medical bill so that insurance covers only part of each bill	49	46	5
Financial incentives for employees who have tests and minor surgery done in clinics and doctors' offices or disincentives for those who have them done in hospitals	28	62	10
Pre-admission reviews requiring employees to obtain approval before admission to hospitals for non-emergency care	25	69	6
Requiring employees to get a second opinion by a medical professional for non-emergency surgery or other non-emergency treatments	28	67	5
Prospective payments to hospitals based on so-called DRG's so that the fees paid to hospitals for treating all patients with particular types of diagnoses are fixed	25	58	17
Prospective payments to doctors based on DRG's so that the fees paid to doctors for treating all patients with particular types of diagnoses are fixed	28	57	15
The opportunity for employees to join an HMO or health maintenance organization in which you pay a monthly fee in advance for nearly all your health and medical care instead of your doctor or hospital billing you or your insurance company each time you use them	32	54	4

(Continued)

Table 4-1 (Continued)

REPORTED PREVALENCE OF DIFFERENT HEALTH
CARE COST CONTROL MECHANISMS

Base: All employees

	Applies	Does Not Apply	Not Sure
Base 1253	%	%	%
The use of a PPO or preferred provider organization for each illness or treatment; the employee can choose from a list of physicians and hospitals which have agreed to provide service to plan participants at a reduced cost	24	71	5
A health promotion or wellness program where employees can get advice and help on how to improve their health and prevent disease	29	66	5
Financial incentives to encourage employees to practice health and safety procedures such as not smoking, using seatbelts, or maintaining proper weight	25	73	2
An employee health advisory service with a nurse available to explain to employees their health benefits, help identify appropriate treatment facilities, and answer related questions	33	65	3
A medical case management program which provides a medical professional to manage high-cost catastrophic illness or injuries by working with the patient, family, and physician to develop long-term treatment plans	15	73	12
A disability case management program which provides a health care professional to work with disabled employees to develop a plan to facilitate the return to work	26	61	13
A salary-related deductible so that higher paid employees have a larger deductible than lower paid employees	9	82	9

Changes in Corporate Health Plans in the Last 3 Years

Table 4-2 shows how many employees and employers report having made each of 18 different changes in their health care plans over the last 3 years.

The number of employers making such changes, and the number of employees affected by them, vary widely from one mechanism to another. For example, half of all corporate benefits officers report that their companies have increased deductibles, and just over half (54%) report that they have instituted second opinions. However, 10% or fewer employers report having started using a PPO, offering an employee health advisory service, offering employees a choice of different health care plans, or using a salary-related deductible.

Observations:

(1) It is a reasonable assumption that the corporate benefits officers' replies are an accurate reflection of the changes made by their companies, but that employees are less well informed, and that their replies reflect their knowledge and perceptions (or misperceptions). However, it is also true that if both samples gave completely accurate replies to this question, there would still be differences. In the

sample of corporate benefits officers, each company has equal weight regardless of the number of employees. The employees' sample, by definition, gives each and every employee (in companies with 500 or more employees) an equal probability of selection and, therefore, includes more employees of large companies than does the employer sample.

(2) Notwithstanding this difference in the two samples, some of the differences between the two groups are striking. For instance, while almost half of all employers report that their companies offer financial incentives to employees to have tests and minor surgery done outside hospitals, only 15% of employees report that their plans include such incentives. It seems highly probable that this difference reflects ignorance on the part of the employees. The same reason—employee ignorance—may also explain the relatively low level of awareness by employees that their plans require prior approval or second opinions.

On the other hand, many more employees than employers (31% as compared with 8%) report that their plans have been changed to offer a choice between different health plans. Whether this reflects a different interpretation of what these words mean—and what actually constitutes a choice—or whether there is some other explanation for this difference is unclear. Indeed, some employees may regard the HMO option as a choice between different plans.

Table 4-2

CHANGES MADE BY EMPLOYERS TO HEALTH PLANS IN LAST 3 YEARS

Q.: (Employees) Now I would like to ask you about changes that your company has made in your health care plan during the last 3 years. During the last 3 years has your employer (READ EACH ITEM)?

Q.: (Corporate Benefits Officers) Now I would like to ask you about changes that your company has made in your health care plans for any of your employees during the last 3 years. During the last 3 years have you (READ EACH ITEM)?

	Employees	Corporate Benefits Officers
Base	1253	1250
	%	%
Changed your plan from a noncontributory to a contributory plan so that you now pay part of your own health insurance premiums	19	21
Required employees such as yourself who previously paid no deductible to pay a deductible	21	24
Increased the deductible you pay	35	50
Required employees such as yourself to cover part of their medical bills where previously the insurance covered the whole cost of these bills	24	22
Increased the proportion of each medical bill paid by employees by reducing the amount paid by the insurance	18	27
Introduced financial incentives for employees who have tests and minor surgery done outside hospitals or disincentives for those who have these done in hospitals	15	47
Started a new program in which employees are required to obtain approval from the insurance company before non-emergency treatment	15	28
Started a new program in which employees are required to obtain second opinions by a medical professional before non-emergency surgery or treatment	22	54
Initiated utilization reviews by health care professionals where no such reviews were required before	N/A	27

(Continued)

Table 4-2 (Continued)

CHANGES MADE BY EMPLOYERS TO HEALTH PLANS IN LAST 3 YEARS

	Employees	Corporate Benefits Officers
Base	1253	1250
	96	86
Offered you the opportunity to join an HMO or health maintenance organization when you did not have that opportunity before	26	34
Started using a PPO, or preferred provider organization, in which you can choose your doctors or hospitals when you need them from a list approved by the plan—or pay a higher cost for using a doctor or hospital not on the list	17	9
Started a health promotion or wellness program where employees can get advice and help on how to improve their health and prevent disease	22	26
Instituted financial incentives to encourage employees to practice health and safety procedures	22	12
Started an employee health advisory service with a nurse available to explain to employees their benefits, treatments, facilities, and answer questions	17	6
Started a medical case management program with a medical professional to work with the patient	8	10
Offered employees a benefits program in which they can choose between different health plans or choose additional benefits	31	8
Started a disability case management program with a health care professional to work with disabled employees	11	12
Started a salary-related deductible plan so that higher paid employees have a larger deductible than lower paid employees	6	7

Note: The plan descriptions shown here are those used in the employee questionnaire. Those used in the employer questionnaire were slightly different (e.g., referring not to "year" but to "employees").

N/A = Not asked of Employees

CHAPTER 5: THE ACCEPTABILITY TO EMPLOYEES OF 17 DIFFERENT CHANGES EMPLOYERS CAN MAKE TO CONTAIN THEIR HEALTH CARE COSTS

Table 5-1 shows the acceptability, or unacceptability, to employees of 17 different changes that employers can make to their health care plans. For each mechanism the responses are shown for all employees—whether or not they have been affected by such changes—and for the minority of employees who report that they have been affected by such changes.

With one exception, majorities of employees report that all of these changes are very or somewhat acceptable. This is true both of employees, in general, and of those who have been directly affected.

The one exception is increased co-payments ("increasing the proportion of each medical bill paid by employees"), which is acceptable to 49% of all employees and 48% of those affected, but unacceptable to 49% of employees and 52% of those affected.

The level of acceptability of these different mechanisms varies greatly. Some changes appear to be perceived as additional benefits and are almost universally welcomed—for example, wellness programs, financial incentives to those who practice health and safety procedures, employee health advisory services, medical case management programs, disability case management programs, and the opportunity to choose between different health plans. It is interesting that many employees also seem to interpret second opinions in this way, as an additional benefit.

Unsurprisingly, changes which involve increased cost-sharing, such as increased employee contributions or increased deductibles (as well as increased co-payments), are accepted much more grudgingly and are not very or at all acceptable to sizable numbers of employees.

There are a number of important similarities and differences between the replies given by employees, in general, and by those who have been affected by specific changes. The reactions of employees directly affected by increased cost-sharing do not differ greatly from those of all employees.

Majorities of those affected by increased employee contributions, increased deductibles, and the introduction of co-payments, report that such changes are acceptable (as do employees, in general). The reactions of those affected by increased co-payments do not differ significantly from those of all employees (with only minorities of 49% and 48%, respectively, finding this change acceptable).

On most of the other changes examined in this question, the proportions of those directly affected who find the changes acceptable are larger (sometimes very much larger) than they are among employees, in general.

Observations:

(1) Table 5-1 provides a powerful evidence that most employees affected by most of the changes that have been made to health care plans over the last few years regard them as at least somewhat acceptable—the one important exception being the slender 52% of those affected by increased co-payments, who regard them as unacceptable.

The responses given by both those affected and by all employees strongly suggest that in the next 2 or 3 years, many employers will be able to increase cost-sharing somewhat, particularly through increased contributions and increased deductibles, without provoking a massive backlash from their employees. However, large numbers of employees, albeit minorities, are strongly opposed to such changes.

(2) The high levels of acceptance of most of the listed changes which do not involve increased cost-sharing, indicate that most employers will find it relatively easy to introduce these elements into their plans; and that, indeed, many of these changes will be perceived not as constraints or reduced benefits, but as additional benefits.

(3) The widespread acceptance of alternative delivery systems such as HMOs and PPOs, particularly by those employees affected, is very striking.

Table 5-1

ACCEPTABILITY TO EMPLOYEES OF CHANGES EMPLOYERS CAN MAKE TO CONTAIN HEALTH CARE COSTS

Base: All employees and all employees affected by each change

Q. (Employees) And how acceptable do you think this change is as a way of containing health care costs—very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable? We'd be interested in your opinion even if this does not apply to your company or your health plan.

		Base	Very Acceptable	Somewhat Acceptable	Not Very Acceptable	Not at All Acceptable	Not Sure
Changed your plan from a noncontributory to a contributory plan so that you now pay part of your own health insurance premiums							
	All employees (Those affected)	1253 (241)	21% (20%)	42% (40%)	18% (19%)	16% (12%)	4% (1%)
Required employees such as yourself who previously paid no deductible to pay a deductible							
	All employees (Those affected)	1253 (257)	20% (15%)	45% (43%)	19% (23%)	14% (18%)	3% -
Increased the deductible you pay							
	All employees (Those affected)	1253 (443)	18% (15%)	36% (39%)	26% (27%)	19% (19%)	2% (1%)
Required employees such as yourself to cover part of their medical bills where previously the insurance covered the whole cost of these bills							
	All employees (Those affected)	1253 (295)	17% (11%)	38% (41%)	26% (29%)	20% (18%)	2% (1%)
Increased the proportion of each medical bill paid by employees by reducing the amount paid by the insurance							
	All employees (Those affected)	1253 (225)	15% (11%)	34% (37%)	29% (33%)	20% (19%)	2% -
Introduced financial incentives for employees who have tests and minor surgery done outside hospitals or disincentives for those who have these done in hospitals							
	All employees (Those affected)	1253 (132)	27% (42%)	41% (41%)	17% (11%)	12% (6%)	3% (1%)
Started a new program in which employees are required to obtain approval from the insurance company before non-emergency treatment							
	All employees (Those affected)	1253 (154)	20% (29%)	33% (44%)	23% (17%)	21% (10%)	2% -
Started a new program in which employees are required to obtain second opinions by a medical professional before non-emergency surgery or treatment							
	All employees (Those affected)	1253 (137)	21% (49%)	37% (35%)	18% (8%)	12% (8%)	3% -

(Continued)

Table 5-1 (Continued)

ACCEPTABILITY TO EMPLOYEES OF CHANGES EMPLOYERS CAN MAKE TO CONTAIN HEALTH CARE COSTS

Base: All employees and all employees affected by each change

		Base	Very Acceptable	Somewhat Acceptable	Not Very Acceptable	Not at All Acceptable	Not Sure
Offered you the opportunity to join an HMO or health maintenance organization when you did not have that opportunity before	All employees (Those affected)	1253 (320)	34% (54%)	36% (26%)	13% (10%)	10% (10%)	6% (1%)
Started using a PPO or preferred provider organization, in which you can choose your doctors or hospitals when you need them from a list approved by the plan—or pay a higher cost for using a doctor or hospital not on the list	All employees (Those affected)	1253 (207)	26% (48%)	36% (34%)	20% (12%)	15% (8%)	3% (1)
Started a health promotion or wellness program where employees can get advice and help on how to improve their health and prevent disease	All employees (Those affected)	1253 (271)	51% (78%)	33% (19%)	9% (2%)	5% (1%)	2% (1%)
Instituted financial incentives to encourage employees to practice health and safety procedures	All employees (Those affected)	1253 (272)	49% (70%)	35% (28%)	8% (2%)	5% (1)	2% (1)
Started an employee health advisory service with a nurse available to explain to employees their benefits, treatments, facilities, and answer questions	All employees (Those affected)	1253 (218)	53% (78%)	33% (20%)	10% (1%)	5% (1%)	2% (1%)
Started a medical case management program with a medical professional to work with the patient	All employees (Those affected)	1253 (101)	43% (78%)	38% (17%)	11% (3%)	6% (5%)	3% (1%)
Offered employees a benefit program in which they can choose between different health plans or choose additional benefits	All employees (Those affected)	1253 (302)	51% (71%)	32% (21%)	9% (3%)	6% (1%)	2% (1%)
Offered a disability case management program with a health care professional to work with disabled employees	All employees (Those affected)	1253 (131)	47% (78%)	36% (18%)	9% (2%)	6% (1%)	3% (1%)
Started a salary-related deductible plan so that higher paid employees have a larger deductible than lower paid employees	All employees (Those affected)	1253 (74)	22% (38%)	30% (42%)	25% (14%)	20% (17%)	3% (1)

* Less than 0.5%.

**CHAPTER 6:
THE EFFECTIVENESS OF 18 DIFFERENT COST
CONTAINMENT MECHANISMS**

Employers are generally optimistic about the effectiveness of many of the cost containment mechanisms studied in this survey. Table 6-1 shows how effective corporate benefits officers think each of these mechanisms are. The replies given by senior corporate executives and human resource executives (not shown here) are broadly similar.

Increased cost-sharing, whether through increased contributions, co-payments, or deductibles, are thought to be effective by the overwhelming majority of employers.

Other mechanisms which are also widely seen to be effective include financial incentives for employees to have tests and minor surgery done outside hospitals, pre-admission reviews, second opinions, utilization reviews, and wellness programs.

Majorities, but smaller ones, of employers also believe in the effectiveness of PPOs, financial incentives to encourage health and safety procedures, and disability case management programs.

Pluralities, but not majorities, of employers believe in the effectiveness of HMOs, employee health advisory services, medical case management programs, and flexible or cafeteria benefits plans.

Employers are more likely to hold opinions about some of these programs than about others. For example, 22% or more of corporate benefits officers are not sure about the effectiveness of PPOs, medical case management programs, or disability case management programs.

Sizable minorities of employers do not share the optimistic, conventional wisdom that these programs are effective. Fully 38% of corporate benefits officers rate HMOs not very, or not at all effective, and 31% have doubts about the effectiveness of financial incentives to employees to practice health and safety procedures. Thirty-three percent rate employee health advisory services as not very, or not at all effective; 38% have similar doubts about flexible or cafeteria benefits plans; and fully 41% do not think that salary-related deductibles are likely to be effective.

Table 6-1

PERCEIVED EFFECTIVENESS OF CHANGES EMPLOYERS CAN MAKE TO CONTAIN HEALTH CARE COSTS

Base: All corporate benefits officers

Q: (Corporate Benefits Officers) And how effective do you think this change is as a way of containing health care costs—very effective, somewhat effective, not very effective, or not at all effective. (We'd be interested in your opinion even if you have no evidence from your own company.)

	Very Effective	Somewhat Effective	Not Very Effective	Not at All Effective	Not Sure
Base: 1250	2%	8%	9%	8%	8%
Changed any plan from a noncontributory to a contributory plan; that employees pay a part of their own health insurance premiums	23	48	18	7	5
Required employees who previously paid no deductible to pay a deductible	34	48	10	2	6
Increased the deductibles paid by employees	31	51	12	3	3
Required employees who previously did not make co-payments to make co-payments to cover part of their medical bills	31	50	10	3	7
Increased the size of co-payments paid by employees	26	52	11	3	8
Introduced financial incentives for employees who have tests and minor surgery done outside hospital or disincentives for those who have these done in hospital	34	47	8	3	8
Started a pre-admission review program for employees who did not need to obtain prior approval previously	31	42	12	4	11
Instituted second opinions by a medical professional for non-emergency surgery or treatment for employees who did not need to get second opinions before	29	44	15	4	8
Instituted utilization reviews by health care professional when no such reviews were obtained before	20	47	14	4	16
Offered an HMO option to employees who did not have that option before	18	31	24	14	13
Started using a PPO or preferred provider organization	12	39	18	8	23
Started a health promotion or wellness program (where employees can get advice and help on how to improve their health and prevent disease)	18	49	18	6	10
Instituted financial incentives to encourage employees to practice health and safety procedures	14	44	25	6	11
Started an employee health advisory service	9	40	26	7	18
Started a medical case management program	10	36	19	5	30
Offered employees a new flexible or cafeteria benefits plan	15	33	25	13	14
Offered a disability case management program	11	41	21	6	21
Started a salary-related deductible plan	10	29	28	13	20

CHAPTER 7: EXPERIENCES OF IMPLEMENTING CHANGES AND COMMUNICATING THEM TO EMPLOYEES

Employers who have increased cost-sharing by their employees in the last three years report widely differing experiences in communicating these changes to employees. Only a relatively small number (from 21% of senior executives to 15% of corporate benefits officers) found that it was very easy to communicate these changes, while large numbers reported that it was very or somewhat difficult.

However, most employers found it easier to get employee acceptance of changes involving increased cost-sharing than they had anticipated.

Observations:

(1) The fact that most employers found it easier than they had anticipated to win employee acceptance of increased cost-sharing is further confirmation that most employees are willing to go along with such changes; and that employee resistance to them can be addressed successfully by employers.

(2) However, the finding that so many employers—including 47% of corporate benefits officers—found it was very or somewhat difficult to communicate these changes, underlines the importance of using the best communication techniques. It would seem that there is much to be learned from employers who have done this successfully.

Table 7-1

HOW EASY OR DIFFICULT EMPLOYERS FELT IT WAS TO COMMUNICATE CHANGES TO THEIR EMPLOYEES

Base: All employers who increased cost-sharing by employees a great deal or somewhat

Q: (Employers) How easy or difficult was it to communicate the changes you made in employee health benefits and the reasons for them—very easy, somewhat easy, somewhat difficult, or very difficult?

	Corporate Employers		
	Corporate Benefits Officers	Senior Executives	Human Resource Executives
Base	641	107	104
	%	%	%
Very easy	15	21	16
Somewhat easy	37	37	43
Somewhat difficult	40	39	31
Very difficult	7	2	10
Not sure	1	1	—

Table 7-2

WHETHER EMPLOYERS' EXPERIENCE IN CHANGING HEALTH PLANS WAS HARDER OR EASIER THAN THEY HAD ANTICIPATED

Base: All whose plans have increased employee cost-sharing a great deal or somewhat

Q: (Employers) Looking back on your experience in making changes in your health care plans, would you say that it was harder or easier to get employee acceptance of changes than you had anticipated?

	Corporate Employers		
	Corporate Benefits Officers	Senior Executives	Human Resource Executives
Base	641	107	104
	%	%	%
Harder	25	15	23
Easier	59	63	59
Same as anticipated	14	19	17
Not sure	3	4	1

Methods Used to Explain Changes to Employees

The overwhelming majority of employees whose plans have changed a great deal or somewhat in the last 3 years report that they received documents describing the changes at their work places. A slender majority (53%) report that the changes were explained at small meetings with 50 or less employees present; just under half report that they received documents at home; and just over one-quarter reported that their companies used larger meetings of 50 or more employees.

The more that each of these techniques were used, the more likely employees were to rate the job done by their employers in explaining these changes favorably.

Observations:

(1) While it is impossible to tell from these data what was the precise impact of each of these four methods of communication, it would seem that all of them help. Employees who rate their employers' communications as excellent were more likely to have been reached by all four methods of communication.

(2) Two of these communications media seem, however, to be particularly effective. Those who rate their employers' communications as excellent were much more likely to have received documents describing the changes at their homes, and much more likely to have attended small meetings of employees than were employees who rate their employers' communications as only fair or poor.

Table 7-3

METHODS USED TO EXPLAIN CHANGES TO EMPLOYEES

Base: All employees whose plans changed a great deal or somewhat

Q: (Employees) Which of the following methods did your employer use to explain the changes in your health plan?

	Job Done by Employer in Explaining Changes			
	Employees	Excellent	Good	Fair or Poor
Base:	340	209	275	252
	79%	50%	62%	49%
Documents describing the plan which were given to employees at work:	85	60	88	76
Documents describing the plan which were sent to employees at their homes:	45	52	48	34
One or more small meetings with less than 50 employees present:	53	68	53	40
One or more large meetings with 50 or more employees present:	28	21	21	26

A majority of employers who increased cost-sharing by their employees believe that their employees understood the need for changes in order to get health care costs under control. Only one-third or less of each of the employer groups think that their employees understood the necessity for changes not very well or not at all well.

Table 7-4

**EMPLOYERS' PERCEPTIONS OF HOW WELL THEIR EMPLOYEES UNDERSTOOD
NECESSITY FOR CHANGES**

**Base: All employers who increased cost-sharing by employees
a great deal or somewhat**

Q. (Employers) How well do you think most of your employees understand the necessity for changes in health care plans in order to get health care costs under control — very well, somewhat, not very well, or not at all?

	Corporate Employers		
	Corporate Benefits Officers	Senior Executives	Human Resource Executives
Base	641	107	104
Very well	22	29	33
Somewhat	47	41	36
Not very well	28	26	28
Not at all well	4	3	3
Not sure	*	1	1

* Less than 0.5%

Job Done By Employer in Explaining Changes In Health Plans To Employees

A majority of employees whose plans changed a great deal or somewhat give their employers positive marks for the job they did in explaining the changes to them. Sixty-seven percent of those whose plans changed a great deal rate the communications efforts excellent or good; only 32% rate them fair or poor.

This response is not uniform. Non-union employees evaluate their employers much more positively than do union members, of whom only 52% rate their employers positively. And employees whose plans changed a great deal are somewhat more likely to rate their employers' efforts as excellent than are those whose plans changed only somewhat.

Table 7-5

JOB DONE BY EMPLOYER IN EXPLAINING CHANGES IN HEALTH PLANS TO EMPLOYEES

Base: All employees whose plans changed a great deal or somewhat

Q. (Employees) How would you rate the job your employer did in explaining the changes in your health plan to you—excellent, good, fair, or poor?

	Employees	Union Members	Non-Union Members	Plan Changed	
				A Great Deal	Somewhat
Base	740	155	583	272	468
	%	%	%	%	%
Excellent	28	16	32	32	26
Good	37	36	38	35	39
Fair	24	34	22	18	28
Poor	10	14	9	13	8
Not sure	1	1	1	1	*

*Less than 0.5%

Adding New Benefits to Make Changes More Acceptable

A majority of employers, but only 30% of employees who have been affected by increased cost-sharing, report that new benefits were added to their plans to make the changes more acceptable.

The new benefit most widely appreciated in these circumstances is the addition of a dental plan. Indeed, no other single type of change seems to have been widely appreciated by more than a handful of employees.

There are several changes which a significant number of employers think were appreciated, but which received hardly any mention by employees. These include increased out-patient benefits, and increased major medical coverage.

Observation:

The significant discrepancy between the replies of employers and employees almost certainly reflects more than the difference between the two samples. It strongly suggests that many employees are scarcely or not at all aware that they have received any additional benefits.

There is general agreement among the great majority of employees who have received additional benefits, employers, and brokers/consultants that these were important in winning the acceptance of employees. Only 14% of employees, and 20% or less of each of the employer groups, think that these additions were not very or not at all important.

Observation:

While these data show that additional benefits do, indeed, help to win employee acceptance for changes, it should be noted that they are by no means essential in every case. Replies to a number of other questions show generally favorable, or at least accepting, reactions to the changes, even where no new benefits were added.

Table 7-6

**MOST APPRECIATED BENEFITS ADDED TO HEALTH PLANS
TO MAKE CHANGES MORE ACCEPTABLE**

**Base: All whose plans have increased cost-sharing by employees
a great deal or somewhat**

Q. (Employees) In making changes in the health plans for employees such as yourself, did your employer also add any new benefits to make the changes more acceptable?

Q. (Employees) What one additional benefit do you think was most appreciated and valued by employees such as yourself?

Q. (Employers) In making changes in the health plans for your employees, did you also add any new benefits to make the changes more acceptable, or for any other reason?

Q. (Employers) What one additional benefit do you think was most appreciated and valued by your employees?

	Employees	Corporate Employers		
		Corporate Benefits Officers	Senior Executives	Human Resource Executives
Base	624	641	107	104
	%	%	%	%
All With Added Benefits	30	55	57	55
Benefits Most Appreciated				
New dental plan	9	12	14	5
Increased dental benefits	1	1	4	2
Vision/eye care benefits	1	2	4	3
Increased outpatient benefits	1	8	7	5
Increased major medical	1	3	6	5
401(k) plan	1	3	1	0
Prescription drug coverage	1	3	2	3
Additional life insurance	1	3	1	6
Short-term disability	1	1	1	1
Long-term disability	1	1	1	1
HMO option	1	1	1	1
Increased accident coverage	1	1	1	3
Increased employer contributions	1	1	2	1
Psychiatric/drug coverage	1	1	1	2
Maternity benefits	1	1	1	2
Wellness program	1	1	1	1
Increased benefits (unspecified)	2			
PPD option	1			
Offered choice of 2 plans	1			
Flexible plans	1			
All other mentions	9	12	11	14
Not sure	3	1	1	2

*Less than 0.5%

Table 7-7

IMPORTANCE OF ADDING BENEFITS IN WINNING EMPLOYEE ACCEPTANCE OF CHANGES IN HEALTH PLANS

Base: All whose plans added benefits and increased cost-sharing

Q. (Employees) How important do you think the addition of new benefits was in winning the acceptance of employees such as yourself to all of the changes in their plans—very important, somewhat important, not very important, or not at all important?

Q. (Employers) How important do you think the addition of new benefits was in winning the acceptance of your employees to all of the changes in their plans—very important, somewhat important, not very important, or not at all important?

Q. (Brokers/Consultants) How important do you think the addition of new benefits was in winning the acceptance of their employees to all of the changes in their plans—very important, somewhat important, not very important, or not at all important?

	Employees	Corporate Employers			Brokers/ Consultants
		Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	189	352	61	57	74
	8%	16%	26%	16%	5%
Very important	44	38	43	40	49
Somewhat important	41	40	41	44	45
Not very important	9	18	11	14	5
Not at all important	5	2	5	2	1
Not sure	1	1			

*Less than 0.5%

The Acceptability of Increased Cost-Sharing

Employee reactions to additional cost-sharing vary widely. Just over half (53%) of employees affected by increased cost-sharing say that this was acceptable. However, substantial numbers say that these changes were either not very acceptable (30%), or not at all acceptable (16%).

The acceptability of increased cost-sharing is substantially dependent on how well or badly employers explain such changes. By 68-32% the great majority of employees who rate their employers' communications efforts as excellent think these changes were acceptable. On the other hand, a 59-41% majority of those who rate their employers' communications as only fair or poor, found these changes to be unacceptable.

Observations:

In this context it is relevant to note that employees whose plans changed a great deal rated their employers' communications efforts as favorably as did those whose plans had changed somewhat (Table 7-5). The results shown in Table 7-8 leave no doubt, therefore, that the acceptability to employees of increased cost-sharing is highly correlated with the quality of corporate communications, regardless of the extent of the changes made. Any employer who does not do a first class job of communicating both the changes, and the reasons for them, can expect to encounter a great deal of employee resistance.

Table 7-8

ACCEPTABILITY OF INCREASE IN COST-SHARING: BY JOB DONE BY EMPLOYER IN EXPLAINING CHANGES

Base: Employees whose cost-sharing has increased a great deal or somewhat

Q: (Employees) The last time your employer increased the cost to employees, how acceptable was this change to you—very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable?

	Job Done By Employer In Explaining Changes			
	All Employees	Excellent	Good	Fair or Poor
Base	624	99	142	171
	9%	16%	23%	28%
Very acceptable	10	21	11	5
Somewhat acceptable	43	47	53	36
Not very acceptable	30	19	26	37
Not at all acceptable	16	13	11	22
Not sure	1	—	—	1

Whether or Not Employees Thought Increased Cost-Sharing Was Necessary

By 57-38% a substantial majority of employees affected by increased cost-sharing believes that the changes were necessary so that their employers could get their health insurance cost under control.

Middle income and more highly paid employees and non-union employees are more likely to think that the changes were necessary. On the other hand, only 51% of those with an income of \$15,000 or less, and only 47% of unionized employees whose cost-sharing has increased, believe that the changes were necessary.

Unsurprisingly, those who think their employers only did a fair or poor job in explaining the changes were also much less likely to believe that they were necessary.

Observations:

These data throw further insights on findings reported earlier. Low income employees are not only the most adversely affected by increased cost-sharing, they are also less likely to think that such changes were necessary.

Unionized employees are also less likely to think that increased cost-sharing is acceptable, and less likely to think that it was necessary.

Table 7-9

WHETHER EMPLOYEES THINK IT WAS NECESSARY TO MAKE CHANGES IN THEIR PLANS TO CONTROL HEALTH CARE COSTS

Base: All employees whose cost-sharing has increased a great deal or somewhat

Q. (Employees) Do you think it was or was not necessary for your employer to make changes in their employee health plan in order to get their health insurance costs under control?

	Base	Was Necessary	Was Not Necessary	Not Sure
All employees	624	57%	38%	4%
By Income From Job				
\$15,000 or less	184	51%	42%	7%
\$15,001 to 25,000	167	59%	35%	6%
\$25,001 to 35,000	130	63%	30%	7%
\$35,001 or more	129	61%	30%	9%
By Type of Employee				
Union	133	47%	48%	5%
Non-union	487	62%	35%	3%
By Job Done by Employer in Explaining Changes				
Excellent	99	66%	29%	5%
Good	142	68%	28%	4%
Fair or poor	171	53%	40%	7%

CHAPTER 8: OTHER EMPLOYEE REACTIONS TO CHANGES IN HEALTH PLANS

Price-Competitive Selection of Physicians

One objective shared by many advocates of reform of the nation's health care system is to increase competition between providers, to stimulate price competition and, thereby, to keep prices from rising as fast as they would in a non-competitive environment.

lower than another doctor's. Clearly there was very little price competition in the marketplace for physicians' services.

In this survey, the same question was put to the sample of employees, and among this segment of the population an even lower 13% report that they have ever chosen a doctor because his or her fees

The Equitable Healthcare Survey: Options for Controlling Costs, a 1983 earlier Harris survey, reported that only 16% of adult Americans had ever selected a doctor because his or her fees were

Table 8-1

WHETHER EMPLOYEES HAVE EVER SELECTED A DOCTOR BECAUSE FEES WERE LOWER: AMONG DIFFERENT GROUPS

Q (Employees) And now some questions about health care services. Have you ever selected a particular doctor because his or her fees were lower than another's, or haven't you?

	Base	Have Selected	Have Not	Not Sure
All Employees	1253	13%	86%	1%
By Income From Job				
\$15,000 or less	308	19%	81%	1%
\$15,001 to \$25,000	354	13%	87%	1%
\$25,001 to \$35,000	392	11%	89%	1%
\$35,001 or more	299	12%	88%	1%
By Age				
18-29 years	333	18%	82%	1%
30-39	404	12%	88%	1%
40-49	258	11%	89%	1%
50 and over	258	12%	88%	1%
By Type of Plan				
Contributory	781	14%	86%	1%
Noncontributory	437	11%	89%	1%
With deductible	883	12%	88%	1%
Without deductible	369	14%	86%	1%
By How Much Employer Has Changed Plan				
A great deal	270	18%	82%	1%
Some what	360	12%	88%	1%
A little	378	11%	89%	1%
Not at all	245	13%	87%	1%

were lower. While the two figures cannot be compared (one relating to the total adult population, and the other to employees of companies with 500 or more employees), it is clear that increased cost-sharing has, as yet, not succeeded in encouraging many employees to shop around for their doctors.

There is evidence in the data, however, that some employees are shopping around and comparing prices, particularly low income employees, employees under 30, and those whose health care plans have been changed a great deal.

Observation:

The findings reported in Table 3-4 indicate that increased cost-sharing has had some effect on consumer behavior, by changing the way in which some people use health care services. However, price competitive shopping for physicians does not seem to be one of the more common ways in which behavior has been changed.

Table 8-2

WHETHER EMPLOYEES OR THEIR FAMILIES FAILED TO OBTAIN CARE THEY NEEDED

Q. (Employees) Was there any time in the last year—since (MONTH ONE YEAR AGO) 1984—that you felt you, or a member of your family covered by the health insurance provided by your employer, needed medical help but did not get it for some reason?

	Base	Yes, Failed to Obtain Care
All employees	1253	5%
By Income		
\$15,000 or less	308	8%
\$15,001-\$25,000	358	4%
\$25,001-\$35,000	112	3%
\$35,001 or more	235	2%
By Type of Plan		
Contributory	742	5%
Non-Contributory	497	4%
With deductible	993	5%
Without Deductible	229	2%
By How Much Employer Has Changed Plan		
A great deal	272	6%
Somewhat	468	3%
Not much	298	3%
Not at all	215	7%

Effect of Changes in Health Plans on Access to Care

One concern which is frequently voiced in relation to many cost control programs is that they may result in reduced access to care. The evidence from this new survey is that changes made so far by corporate employers have done little, if anything, to reduce access. Only 5% of employees report that they failed to get needed care in the previous 12 months (and less than half of these—2% of all employees—failed to obtain it because of inadequate insurance).

Observations:

(1) While access to care has not yet been adversely affected to any measurable degree by increased cost-sharing, there is some indication that access could be adversely affected by increased cost-sharing in the future. Low income employees, with earnings of \$15,000 or less, are twice as likely as other employees to say that they have failed to obtain needed care. Employees with plans that require deductibles are more likely to have failed to obtain needed care than are employees who do not have to pay deductibles.

Table 8-3

WHETHER EMPLOYERS MADE ANY CHANGES TO WHICH EMPLOYEES WERE STRONGLY OPPOSED -- AND WHAT THOSE CHANGES WERE

Q. (Employees) Is there any one change to your employer's benefits or health insurance plans in the last few years to which you were strongly opposed, or not—and, if so, what was that change?

Q. (Employers) Is there any one change to your employee benefits plans that you made in the last few years to which your employees reacted in a particularly hostile way, or not—and, if so, what was that change?

	Employees	Corporate Employers		
		Corporate Benefits Officers	Senior Executives	Human Resource Executives
Base	1251	1250	200	200
	%	%	%	%
No change to which employees were strongly opposed	73	69	76	69
Increased deductibles	8	11	7	12
Increased contribution to premiums	3	3	5	2
Instituted deductibles	7	—	—	—
Increased copayments	—	1	3	4
Charged insurance provided	—	2	1	2
Selected services	—	2	2	3
Increased service costs	—	1	—	2
Made change but change not specified	17	10	8	5

(2) Even a small increase in the percentage of employees failing to obtain needed care would be very serious, with each percentage point increase representing many hundreds of thousands of employees and their families. It would be important to include this question in any future survey of the employed population to determine whether or not access to care deteriorates as employers take further steps to get their costs under control.

Employee Opposition to Specific Changes Made to Their Plans

The great majority of employees report that their plans have not incorporated any changes in the last few years to which they were strongly opposed—a finding which is confirmed by most employers.

The two changes to which the most number of people reacted negatively were increased deductibles and increased contributions to premiums.

Observation:

These results add further confirmation to the finding that steps taken to control health care costs so far have generally not provoked a strong, hostile reaction from employees.

**CHAPTER 9:
LOOKING TO THE FUTURE AND LESSONS
LEARNED FROM THE PAST**

Changes most Effective in Containing Costs

The experiences of employers and brokers/consultants vary widely as to which changes are the most effective in helping to contain costs. Between 17-21% of the employer groups mention increased deductibles. Only 12% or less of any of the employer groups mention any other single change.

Observation:

The many different answers given to this question may reflect the different judgments of different individuals, or the different experiences of different companies. However, it is evident that no single health care cost containment mechanism is a panacea, and that to be really effective, a cost containment program needs to include a substantial number of different elements.

Table 9-1

CHANGES MOST EFFECTIVE IN CONTAINING COSTS

Q. (Employers) Which one change in your employee health care plan do you think has been, or will be, the most effective in helping to contain health care costs?

Q. (Brokers/Consultants) What do you consider the single most important element of plan design which employers can adopt to control their health care costs?

	Corporate Employers			Brokers/ Consultants
	Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	1250	260	200	110
	%	%	%	%
Increased deductible	17	21	17	6
Pre-admission plan/program	9	5	5	12
HMO plan	4	6	6	—
Financial incentive/rebates/ cash incentives	2	1	1	8
Outpatient benefits 100% outpatient surgery	3	2	6	11
Second opinion	3	6	12	5
Utilization review	2	1	2	4
Co-payment plan	3	6	6	13
Increased co-payments	2	3	5	4
Comprehensive plan	2	1	3	1
Preferred provider organization (PPO)	2	1	4	2
Monitor claims cost	1	0	—	1
Contributory plan/employee contribution employees contribute to premium	3	11	2	6

(Continued)

Table 9-1 (Continued)

CHANGES MOST EFFECTIVE IN CONTAINING COSTS

	Corporate Employers			Brokers/ Consultants
	Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	1250	200	200	110
	%	%	%	%
Self-funding/self-insured	4	5	4	-
Catastrophe plan	1	12	1	-
Flexible benefit plan	2	1	2	4
Wellness program/encourage preventive medical care	2	1	2	6
Educating employees/communication with employees	3	2	3	6
Instituted deductibles/discontinued full dollar coverage	5	4	3	-
Increased cost sharing	1	2	1	8
Disincentive plan	2	1	3	8
Limited hospital benefits/disincentives for hospitalization	1	3	-	3
Changed carrier	1	2	3	-
Revised stop-loss/rebated plan	-	1	-	1
Nothing	4	4	3	1
All other mutations	6	4	6	11
Don't know/no answer	2	6	2	-

*Less than 0.5%.

Most Important Lessons Learned So Far

While many different answers are given by employers and consultants as to the most important lessons they have learned from steps they have taken to control health care costs, one answer stands out. Fully 36% of corporate benefits officers and of brokers/consultants say that the value of good communications with employees (including the need to educate employees), stands out as the most important lesson learned.

Observation:

This finding should not be interpreted to mean that the details of plan design are unimportant. However, it certainly underlines the vital importance of careful and effective communications.

Table 9-2

MOST IMPORTANT LESSON LEARNED FROM STEPS TAKEN TO CONTAIN HEALTH CARE COSTS

Q.: (Employers) With hindsight, what do you think is the most important lesson that you and your corporation have learned from all that you have done recently to try to contain health costs—a lesson that, perhaps, could be helpful to other employers?

Q.: (Brokers/Consultants) With hindsight, what do you think is the most important lesson that you have learned from all that the companies you work with have done recently to try to contain health costs—a lesson that, perhaps, could be helpful to other employers?

	Corporate Employers			Brokers/ Consultants
	Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	1250	200	200	110
	%	%	%	%
Value of good communication with employees/educating employees	36	21	25	36
Employees should share cost/employee contribution	5	11	9	7
Value of self-funding/self-insurance	2	2	3	2
Need to review/monitor plan/benefits/bills/costs	7	8	4	9
Value of increased/raising deductibles	2	3	2	
Need for communications with medical community	2	3	1	

(Continued)

Table 9-2 (Continued)

**MOST IMPORTANT LESSON LEARNED FROM STEPS TAKEN TO
CONTAIN HEALTH CARE COSTS**

	Corporate Employers			Brokers/ Consultants
	Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	1250	200	200	110
	%	%	%	%
Value of offering/choice of plans/benefits	1	2	1	1
Should have implemented changes sooner	2		2	4
Value of good/tight administration/administrative control	2	1	3	5
Need to understand policy before implementing	1			
Value of flexible benefit plan	1	2	1	1
Need for employee involvement/input	3	1	2	3
Value of co-payment plan	1	3	1	1
Need to include cost containment features/measures	2	3	5	4
Benefits of cost sharing	1	1	3	
Need to hire a consultant/rely on accountant/insurance agent	1		1	
Need for a wellness program	1			3
Need to shop around for best appropriate plan	2	4	4	5
Didn't make changes	3	3	2	1
It's difficult/impossible to contain costs/recently implemented changes	6	6	6	4
It's too soon to tell	2	2	1	
None/no lessons to learn	5	3	4	

How Much Can Individual Employers Do by Themselves

Most employers and consultants are at least somewhat optimistic that what they do can have a real impact on their health care costs. Relatively few employers accept the argument that they are at the mercy of the national economy, and that there is little they can do until national health care cost inflation is brought under control.

Table 9-3

HOW MUCH INDIVIDUAL EMPLOYERS CAN DO BY THEMSELVES TO CONTROL THEIR HEALTH CARE COSTS

Q. (Employers) Many different factors are thought to add to health care costs and spending including new medical technologies, government programs such as Medicare and Medicaid, the aging of the population, and the third party payment system. Realistically, how much do you think individual employers such as yourself can do by themselves to slow down the increase in their own health care costs—a great deal, some, not much, or nothing at all?

Q. (Brokers/Consultants) Many different factors are thought to add to health care costs and spending including new medical technologies, government programs such as Medicare and Medicaid, the aging of the population, and the third party payment system. Realistically, how much do you think individual employers can do by themselves to slow down the increase in their own health care costs—a great deal, some, not much, or nothing at all?

	Corporate Employers			Brokers/ Consultants
	Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	1250	200	200	110
A great deal	20	19	15	36
Some	56	52	60	50
Not much	80	29	23	13
Nothing at all	2	1	1	1
Not sure				

*Less than 0.5%

Expected Rate of Change in Health Care Plans Over the Next Three Years

If employer expectations are accurate, the next 3 years will see more changes in corporate health care plans than have been implemented in the last 3 years. While many employers (between 33-41% of the 3 groups surveyed) expect to see about the same rate of change over the next 3 years, most of the remainder expect to see a faster rate of change.

A slim majority of brokers and consultants expect greater rates of change in corporate health care plans during the next three years: 51% of brokers/consultants expect more changes in the next 3 years than have been implemented during the last 3 years.

Table 9-4

EXPECTATIONS FOR MAGNITUDE OF CHANGES IN HEALTH PLANS OVER NEXT THREE YEARS

Q: (Employers) Looking ahead to the next 3 years, do you expect to make more changes, less changes, or about the same amount of changes to your health care plans as you made in the last 3 years?

Q: (Brokers/Consultants) Looking ahead to the next 3 years, do you expect the companies you work with to make more changes, less changes, or about the same amount of changes to their health care plans as they made in the last 3 years?

	Corporate Employers			Brokers/ Consultants
	Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	1250	200	200	110
	%	%	%	%
More changes	40	33	39	51
Less changes	20	23	26	21
About the same amount of changes	38	41	33	27
Not sure	3	3	3	1

Observation:

It is necessary to be cautious when making forecasts of future behavior from current expectations and intentions. However, it is reasonable to interpret the replies as indicating that the rate of change is unlikely to be any slower in the immediate future than it has been in the recent past, and may well be faster.

The Likely Impact of Tax Changes Affecting Employee Benefits

The elimination or reduction of tax exemption for employee benefits is a hotly debated issue in Washington. The indications from this survey are that most companies probably would not decrease their employee benefits even if they became taxable. However, a sizable minority of employers (between 24-32% of the three groups) expect that their companies would cut employee benefits if they became taxable.

A majority of brokers and consultants take a different view, believing that most employers would decrease benefits under these circumstances.

Table 9-5

EXPECTED EFFECT OF ELIMINATING OR REDUCING TAX EXEMPTIONS ON EMPLOYEE BENEFITS

Q: (Employers) As I'm sure you know, there is a possibility that Congress will eliminate or reduce the tax exemptions for some or all employee benefits, thereby increasing their cost to employees. If this happens, do you think that over the long term your company will increase or decrease employee benefits, or will it make no difference?

Q: (Brokers/Consultants) As I'm sure you know, there is a possibility that congress will eliminate or reduce the tax exemptions for some or all employee benefits, thereby increasing their cost to employees. If this happens, do you think that over the long term companies will increase or decrease employee benefits, or will it make no difference?

	Corporate Employers			Brokers/ Consultants
	Corporate Benefits Officers	Senior Executives	Human Resource Executives	
Base	1250	200	200	110
	80	80	80	80
Employers will increase benefits	5	6	8	5
Employers will decrease benefits	27	24	32	56
Benefits will not change	58	64	54	36
Not sure	10	7	7	3

APPENDIX: SURVEY METHOD

Sample Design

The following separate samples were used in this study:

Employees of corporations with 500 or more employees. A nationwide cross-section of 7073 adults was screened in order to locate a representative sample of 1,253 employees. The initial sample was generated by random-digit dialing, based on an unclustered sampling frame, stratified by region and by the Census Bureau's "size of place" designations.

Employers. Three separate samples of employers were interviewed. Three systematic samples of corporations were drawn from the Dunn & Bradstreet listing of corporations with 500 or more employees in the U.S.

- One sample of corporations was used to generate **1,250 corporate benefits officers**.
- A second sample of corporations was used to draw a sample of **200 senior executives** (executive vice president level or above).
- A third sample was used to draw a sample of **200 senior human resources executives**.

Each of these three samples was drawn separately, and should not be aggregated. While each sample is projectable to its universe, the aggregate would not be representative of any universe.

Brokers and Consultants. Interviews were completed with 110 senior executives working in insurance brokerage and consulting firms.

- Forty of these interviews were with senior employee benefits experts in the head offices and regional offices of the ten largest brokerage firms.
- Forty of these interviews were in 40 of the larger medium-sized insurance brokerage firms.
- Ten interviews were with group health insurance consultants in the larger accounting firms, and 20 interviews were with group health insurance consultants in consulting firms.

These 110 interviews were drawn selectively with key individuals targeted in the larger firms in each segment. Unlike the samples of employees and employers, this is not a strict probability sample and the replies of the consultants cannot be projected to be accurately representative of all brokers and consultants. The findings for this sample are, therefore, indicative and not definitive.

Interviewing

All interviews were conducted by telephone from the New York offices of Louis Harris and Associates, during February and March 1985. The employee sample was interviewed at home from 5 P.M. to 10 P.M. (local time) on weekdays, and from 10 A.M. to 10 P.M. (local time) on weekends. The employer/broker and consultant samples were interviewed on weekdays from 9 A.M. to 5 P.M. Where necessary, appointments were made to interview the relevant individual within the organization contacted.

Up to three callback attempts were made to reach all selected respondents.

Questionnaires

Three questionnaires were developed for this survey: one for employees, one for employers (corporate benefits officers, senior executives, and human resource executives), and one for brokers/consultants. Many of the questions were very similar, with employees answering questions about themselves, employers answering questions about their employees, and brokers/consultants answering questions about the companies which they advise and work with. Copies of the questionnaires can be obtained from Louis Harris and Associates.

Data Processing

The editing, coding, and data processing of all questionnaires were conducted by Louis Harris and Associates.

Codes were developed for responses to open-end questions, with only those responses given by less than 0.2% of the respondents being coded as "other" responses.

The data were analyzed and tabulated separately for each of the five samples.

Sampling Error

The table below indicates the sampling error associated with the various samples sizes and the reported sample percentages at the 95% confidence level.

REPORTED SAMPLE PERCENTAGE

Sample Size	10% or 90%	20% or 80%	30% or 70%	40% or 60%	50%
1,250	3%	2%	1.5%	1.2%	1%
2,500	2%	1.5%	1%	.8%	.7%
5,000	1.5%	1%	.8%	.6%	.5%

DEMOGRAPHIC PROFILE OF THE EMPLOYEE SAMPLE

	%
All Employees	100
Region¹	
East	25
Midwest	27
South	34
West	15
Sex	
Male	66
Female	35
Employer's Business	
Manufacturing	47
Wholesale, retail	11
Financial	11
Services	17
Other	15
Income	
\$15,000 or less	25
\$15,001 to \$25,000	28
\$25,001 to \$35,000	25
\$35,001 or more	19
Age	
18-29 years	31
30-39 years	32
40-49 years	21
50 or over	16
Labor Union	
Self	23
Other in family	5
No one	72
Family Size Covered	
1	29
2	23
3 or more	47

¹Definition of Geographic Regions Used by Louis Harris and Associates

East: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Delaware, Maryland, District of Columbia, and West Virginia.

South: Virginia, North Carolina, South Carolina, Florida, Georgia, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Texas, and Oklahoma.

Midwest: Ohio, Michigan, Indiana, Illinois, Wisconsin, Minnesota, Iowa, Missouri, Kansas, Nebraska, South Dakota, and North Dakota.

West: Montana, Wyoming, Colorado, New Mexico, Arizona, Utah, Idaho, Nevada, California, Oregon, and Washington.

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The Equitable Survey IV:

CORPORATE INITIATIVES & EMPLOYEE ATTITUDES ON FLEXIBLE BENEFITS AND CAFETERIA PLANS

Conducted for The Equitable Life Assurance Society of the United States
by Louis Harris and Associates

February and March 1985

Project Directors:

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INTRODUCTION

The purpose of **The Equitable Survey IV** is to provide information which will aid corporate decisionmakers who are considering offering flexible benefits or cafeteria plans to their employees in the next few years. The survey examines various flexible benefits which employers have introduced, how well the new plans are working, and what employers expect to do in the near future.

This survey establishes a number of benchmarks. It is the first substantial nationwide survey:

- To measure the incidence of flexible benefits in medium-sized and large corporations, and project the incidence in two years;
- To document the experiences of corporate employers who have introduced flexible benefits plans;
- To record how employees have reacted to changes in their benefits and the chance to choose which benefits they receive; and
- To contrast the perceptions of corporate employers who do not offer flexible benefits with the experiences of employers who offer flexible benefits to their employees.

The Equitable Survey IV is the second report to emerge from a study conducted in 1985 by Louis Harris and Associates for the Equitable Life Assurance Society of the United States. The first report, **The Equitable Health Care Survey III: Corporate Initiatives and Employee Attitudes on Cost Containment**, was published in June 1985. **The Equitable Health Care Survey III** is the first detailed study of how corporations have fared in their efforts to contain employee health care costs, how employees have reacted to changes in their health care benefits, how acceptable they find these changes, and how their use of health care services has been affected by these changes.

Fieldwork

Interviews for both the Equitable Survey III and Equitable Survey IV were conducted in February and March 1985 with the following samples, all of which are designed to be representative of the populations from which they are drawn:

- A national cross section of 1,253 employees of corporations with 500 or more employees;
- A national cross section of 1,250 corporate benefits officers in companies with 500 or more employees;
- A national cross section of 200 senior executives in companies with 500 or more employees;
- A national cross section of 200 senior human resource executives in companies with 500 or more employees; and
- One hundred and ten national and regional insurance brokers and consultants who work with corporate clients in the field of group health plans.

Note on the Tables

Percentages in the tables may not add to 100% because of rounding or the acceptance of multiple responses.

Acknowledgements

Louis Harris and Associates is indebted to The Equitable Life Assurance Society of the United States for making this research possible. The contribution of the following individuals is gratefully acknowledged: Richard Freiburger, James Glynn, and Arthur Lifson. Each of these individuals made important contributions to the design of the study and the development of the questionnaire.

Final responsibility for the design and implementation of the survey and for the findings and conclusions contained in this report rests with Louis Harris and Associates.

SURVEY HIGHLIGHTS

This summary provides an overview of the results of this survey. Many findings described in the body of this report do not appear in this summary, and interested readers are urged to examine the full report for these details.

1. **Relatively few corporations of 500 or more employees currently offer flexible benefits or cafeteria plans to employees.** Between 15-16% of corporate benefits officers, senior executives and human resources officers describe their plans as flexible benefits or cafeteria plans.
2. **However, many different features which give employees choices of benefits are included in the plans of corporations whose officers do not consider their plans flexible or cafeteria plans.** Eighty percent of employees report that their plans include at least some choice of benefits, but many of these individual features are available to less than a quarter of all employees (24% or less).
3. **The three most common flexible features which employees say they have** in their plans are the right to include or exclude life insurance (58%), the right to include or exclude a dental plan (41%), and a choice of two or more basic health plans (36%).
4. **An overwhelming majority of employees like having a choice of benefits:** 65% of employees say that they like it a lot, and 21% say that they like it a little. Corporate benefits officers are well-informed about this popularity, but they underestimate just how much employees like having some control over which benefits they receive.
5. **Employees who have some choice of benefits are more satisfied with their jobs, salaries and benefits, than are employees who have no choice of benefits.** For example, forty-nine percent of employees who have some choice of benefits say they are very

satisfied with their benefits, compared to only 40% of employees who have no choice of benefits. And 55% of employees who have choices between benefits say they are very satisfied with their jobs, while only 45% of employees with no choice of benefits say they are very satisfied.

This higher level of satisfaction among employees with a choice of benefits indicates that employers who introduce flexible benefits may also find that they improve employee satisfaction with jobs, salaries, and benefits.

6. **A substantial minority of employers report adding flexible features to benefits plans to make increased cost-sharing and other changes in health plans more acceptable to employees.** Eighty-one percent of employees whose health plans have changed a great deal or somewhat during the past three years say they have some choice of benefits. These include dental and eye care plans, 401(k) plans, a choice of two health plans, flexible spending plans, an HMO option, and full flexible plans.

These measures appear to help win employee acceptance of changes in their health plans. More employees who have a choice of benefits regard changes in their health plans as very acceptable than do employees who have no choice—36% to 26%, respectively.
7. **Employees voice nearly unanimous support for their employers' decision to offer a choice of benefits.** Ninety-one percent of employees who have some choice between benefits think this decision was at least a somewhat good one, with 56% calling the decision a very good one.

8. **It appears that thorough, clear communications is almost as important in winning employee support for flexible benefits as the benefits themselves.**

There is a powerful correlation between how well employers explain changes in benefits plans and employee support for the introduction of choice into benefits plans. Employees who say their employers did an excellent job explaining changes are far more likely to favor the decision to offer choices of benefits than are employees who say their employers did a fair or poor job explaining changes to them.

9. **Flexible benefits plans appear to help control corporate health care and other benefits costs. Large majorities of employers believe that flexible benefits are effective in controlling the cost of benefits.**

However, a large gap separates the experiences versus the perceptions of corporate benefits officers who do or do not have flexible plans, about the effectiveness of flexible benefits in controlling the cost of benefits. Thirty-five percent of benefits officers whose firms have flexible benefits plans rate them very effective in controlling costs of benefits, compared to only 14% of benefits officers whose firms don't have flexible benefits plans.

This gap is particularly significant because benefits officers whose firms have flexible plans consider controlling the cost of benefits the most important reason for having flexible benefits plans.

But even larger majorities of employers also recognize that flexible benefits are effective in improving benefits for employees; improving employee satisfaction with their benefits; meeting the needs of different types of employees; educating employees about the real costs of their benefits; and improving employee morale and loyalty.

10. **Corporate benefits officers' initial concerns about the magnitude of problems caused by flexible benefits plans are not borne out by the experiences of companies which have put in flexible benefits plans.**

There are immense differences between the perceptions of employers who don't have flexible plans and the experiences of employers who do. For example:

- Only 14% of officers whose firms have flexible plans consider the difficulty or cost of administering these plans a major problem, compared to 64% of officers whose firms don't have them; and
- Only 9% of officers whose firms have flexible plans say that an increase in the overall cost of benefits plans as a result of introducing choice has been a major problem. Thirty-nine percent of officers whose firms don't have these plans believe that increased overall costs of benefits would be a major problem.

However, employers' experiences with flexible benefits plans have not been trouble-free, with about half reporting minor problems with their new plans.

But the striking finding is that most companies with flexible benefits plans have not had major problems with them. In fact, they consider them effective, popular, and they look set to introduce even more features to their plans in the near future.

11. **Nearly all of these employers feel that the decision to offer employees choices between benefits was a good decision.**

Sixty percent of these employers feel that their decision was a very good one, and 35% feel it was a somewhat good decision.

12. Employers expect the use of features which give employees a choice of benefits to increase dramatically in the next two years. For example:

- The option to include or exclude life insurance is expected to rise in corporations which have flexible benefits plans now from a current level of 67% to 82%. Among corporations which currently do not have flexible benefits plans, the prevalence of this option is expected to rise from 40% now to 61%.
- The option to include or exclude a dental plan is expected to rise in corporations which have flexible benefits plans now from a current level of 44% to 64%. The level of this option in corporations which do not have a flexible benefits plan now is expected to rise from 26% to 44%.
- The option to make additional contributions for extra benefits is expected to rise in corporations which have flexible benefits plans now from a current level of 20% to 49%. The level of this option in corporations which do not have flexible benefits plans now is expected to rise from 10% to 39%.

Employers also predict large increases in the prevalence of many other flexible benefits features. However, even with these increases, employers in companies which do not have flexible benefits plans now report that most of these features will still be unavailable to majorities of their employees.

13. These increases in features which give employees choices between benefits may contribute to a doubling within two years of the incidence of corporations which offer full-fledged flexible benefits plans — as opposed to plans which have only a few or no flexible benefits features. Between 13-19% of corporate employers expect to introduce flexible benefits or cafeteria plans in the next two years. If these expectations are accurate, the incidence of these plans in corporations with 500 or more employees will rise from 15-16% today to between 28-33%.

14. A caveat: there are dangers in particularizing from the overall findings to an individual employer, benefits plan, or employee. This report shows a wide variety of different actions by employers, effects, attitudes, and reactions. Readers should recognize that even where substantial majorities give one answer to a question, minorities—usually representing millions of employees—disagree with the majority.

CHAPTER 1: CURRENT AND FUTURE USE OF FLEXIBLE BENEFITS AND CAFETERIA PLANS

Current Use of Flexible Benefits and Cafeteria Plans

A relatively modest proportion of employers in corporations with 500 or more employees, which were the focus of this study, report that they now offer flexible benefits or cafeteria plans to their employees. Between 15-16% of corporate benefits officers, senior executives and human resource executives describe their employee benefits plans as either flexible benefits or cafeteria plans. Corporate benefits officers also report that

these plans are significantly more prevalent in the West (20%) than in the East (12%), and slightly more common in the West than in the Midwest and South. The vast majority of all three employer groups say that neither of these two terms describes their employee benefit plans.

Those corporate benefits officers who describe their benefits plans as flexible or cafeteria plans say these plans are available, on average, to two-thirds (67%) of their employees.

Table 1

PERCENTAGE OF EMPLOYERS WHO DESCRIBE PLANS AS A CAFETERIA PLAN OR FLEXIBLE BENEFITS PLAN

Q.: (Employers) Different people use different words to describe their plan. Would you describe your plan as a cafeteria plan, as a flexible benefits plan, or what?

	Corporate Benefits Officers						
	Total	By Region				Senior Executives	Human Resource Officers
		East	Mid-west	South	West		
Base	1250	410	300	344	196	200	200
	%	%	%	%	%	%	%
Cafeteria plan	3	2	2	3	5	2	3
Flexible benefits plan	12	11	14	10	15	14	12
Neither	84	86	82	86	79	82	84
Not sure	2	2	1	2	1	3	2

Observation:

When asked if the terms flexible benefits or cafeteria plan described their companies' plans, employers made their own interpretation of these terms. No standard definition was read to respondents. Thus, some employers who offer some choice of benefits to employees defined these terms more stringently than just the availability of choice, which may account in part for the low incidences reported in Table 1.

Table 2**PERCENTAGE OF EMPLOYEES WHO HAVE FLEXIBLE BENEFITS OR CAFETERIA PLANS WITHIN FIRMS THAT OFFER THEM**

Base: Corporate benefits officers who describe plan as a flexible benefits or cafeteria plan

Q.: (Corporate Benefits Officers) Approximately what percentage of your employees have cafeteria or flexible benefits plans?

	Corporate Benefits Officers
Base: 184	%
Mean	67

Prevalence of Flexible/Cafeteria Features in Benefits Plans

Table 3 shows three different measures of the prevalence of 11 flexible features which appear in employee benefits plans. The first column shows the number of employees in corporations of 500 or more employees who report that their benefits plans include these features. The second and third columns show the prevalence of each of these features in companies which do or do not offer flexible benefits plans to employees. And the fourth column shows what brokers/consultants who work with corporate clients on group plans believe is the prevalence of these features.

The replies of employees show that there is wide variation in the use of these features in employee benefits plans. Although 80% of employees report that their plans include at least one of these 11 features, their responses also show that most of these features are available to relatively small minorities of employees (24% or less). The three most common features reported by employees are the right to include or exclude life insurance (58%), the right to include or exclude a dental plan (41%), and a choice of two or more basic health care plans (36%).

Corporate benefits officers whose firms do or do not offer flexible benefits plans to their employees report significant differences in the use of these features. However, it is notable that minorities of employers who state explicitly that their firms do not have flexible benefits plans also report that their employee benefits plans include features which give employees a choice of benefits.

In contrast to the low levels reported by employees and corporate benefits officers, brokers/consultants report that majorities of their corporate clients offer six of the eleven features in Table 3.

Observations:

(1) The replies given by employees in Table 3 are a measure of what employees believe their plans include. They may not be accurate beliefs, but the proportions reported for most features are close to the proportions reported by corporate benefits officers. Two exceptions are the prevalence of flexible spending plans and the right to invest in a 401(k) plan. This apparent underreporting by employees suggests that employees don't know that their firms offer these benefits, or that their employers offer these benefits under different names. The high level of "not sure" responses given to the latter also suggests that many employees don't understand what a 401(k) plan is.

(2) It should be emphasized that although only 15% of corporate benefits officers report offering employees flexible benefits or cafeteria plans, many features which commonly appear in such plans are available to minorities, which represent many millions of employees. It appears that the benefits officers who offer employees some choice but don't regard their plans as flexible benefits plans feel there is not enough choice to define the plans as such.

(3) Brokers/consultants were asked if these features applied to any of the employees in companies they worked with, which may have included dozens of companies of all sizes. As such, brokers/consultants responses and those of the corporate benefits officers reflect different universes, and are not strictly comparable.

Table 3

PREVALENCE OF VARIOUS FLEXIBLE/CAFETERIA BENEFITS IN EMPLOYEE BENEFIT PLANS

Q.: (Employees) Do the following apply to your benefits plan with your company?

Q.: (Employers) I will read you some types of flexible benefit plan options. Would you please say for each one if it already applies to any of your employees, or if it is something you expect to apply to some employees in the next 2 years, or if it does not apply and will not apply.

Q.: (Brokers/Consultants) I will read you some types of flexible benefit plan options. Would you please say for each one if it already applies to any of the employees of any of the companies you work with, or if it is something you expect to apply to some employees in the next 2 years, or if it does not apply and will not apply.

		Applies Now		
		Corporate Benefits Officers		Brokers/ Consultants
		Offer Cafeteria or Flexible Benefits Plan	Do Not Offer Cafeteria or Flexible Benefits Plan	
	Employees			
Base	1253	184	1047	110
	%	%	%	%
The right to include or exclude life insurance or vary the amounts	58	67	40	77
The right to include or exclude a dental plan	41	44	26	61
The employee's right to choose between two or more basic health care plans—for example, plans with different employee contributions, deductibles, or co-payments	36	36	16	56
The right to include or exclude an eye care plan	24	19	8	38
The right to make additional contributions for extra benefits	22	20	10	60
The right to invest in a 401(k) plan	15	41	34	83
The so-called flexible spending plan in which you can pay for certain benefits with pre-tax dollars	13	23	3	53
The right to include or exclude auto insurance	10	NA	NA	NA
The right to trade paid time off for other benefits or cash	9	8	3	28
The right to include or exclude legal insurance	7	5	2	14
The right to trade off health care benefits for other non-health care benefits or cash	6	13	1	37

NA = Not asked

Prevalence in the Near Future of Flexible/Cafeteria Benefits

Table 4 shows that in the next two years, the use of these 11 flexible benefits features will increase dramatically in corporations with 500 or more employees—if the expectations of corporate benefits officers are accurate. However, most of these features will probably still be unavailable to majorities of employees who work in companies which do not currently offer flexible benefits or cafeteria plans.

Brokers/consultants also expect rapid growth during the next two years in the use of these features among the companies which they work with on group plans.

Not surprisingly, within two years these increases may result in a doubling of the incidence of corporations which describe their plans as full-fledged flexible benefits plans—as opposed to benefits plans which have only a few or no flexible/cafeteria features. Table 5 shows that 19% of corporate benefits officers, 13% of senior executives, and 14% of human resource executives expect their companies to introduce flexible benefits or cafeteria plans in the next two years. If these expectations are accurate, the incidence of flexible benefits and cafeteria plans in

corporations with 500 or more employees will rise from 15-16% today to between 28-33%. And if corporate benefits officers' expectations about their regions are accurate, then the incidence of flexible benefits and cafeteria plans in the Midwest and West may be significantly higher—about 40%—than in the East (30%) and the South (28%).

Observation:

The tables in this chapter suggest something important about the way that most corporate employers are building flexible benefits into their employee benefits plans. They appear to introduce features individually, or a few at a time—to see how employees react to them, how well they work, and to help win employee acceptance of changes in health plans and increased cost-sharing. (Table 10 of this report, which also appeared in Equitable Survey III, shows that a majority of employers who have increased employee cost-sharing have increased benefits to ease the pain of this increased burden.) Only a vanguard appear to have replaced traditional benefits plans with full-fledged, multi-feature flexible benefits plans. However, it should be understood that this is a conclusion inferred from the overall pattern of results in this study.

Table 4

**PREVALENCE IN THE NEAR FUTURE OF VARIOUS FLEXIBLE/CAFETERIA BENEFITS
IN EMPLOYEE BENEFIT PLANS**

Q.: (Employers) I will read you some types of flexible benefit plan options. Would you please say for each one if it already applies to any of your employees, or if it is something you expect to apply to some employees in the next 2 years, or if it does not apply and will not apply.

Q.: (Brokers/Consultants) I will read you some types of flexible benefit plan options. Would you please say for each one if it already applies to any of the employees of any of the companies you work with, or if it is something you expect to apply to some employees in the next 2 years, or if it does not apply and will not apply.

	Will Apply in Next 2 Years				
	Corporate Benefits Officers		Senior Executives	Human Resource Officers	Brokers/Consultants
	Now Offer Cafeteria or Flexible Benefits Plan	Do Not Now Offer Cafeteria or Flexible Benefits Plan			
Base	184	1047	200	200	110
	%	%	%	%	%
The right to include or exclude life insurance or vary the amounts	82	61	60	62	86
The right to include or exclude a dental plan	64	44	48	43	75
The employee's right to choose between two or more basic health care plans—for example, plans with different employee contributions, deductibles, or co-payments	53	36	33	42	76
The right to include or exclude an eye care plan	39	25	27	26	57
The right to make additional contributions for extra benefits	49	39	39	40	83
The right to invest in a 401(k) plan	65	64	58	61	95
The so-called flexible spending plan in which you can pay for certain benefits with pre-tax dollars	38	22	14	21	75
The right to include or exclude auto insurance	NA	NA	NA	NA	NA
The right to trade paid time off for other benefits or cash	21	14	15	10	49
The right to include or exclude legal insurance	8	6	6	7	35
The right to trade off health care benefits for other non-health care benefits or cash	32	18	15	13	63

NA = Not asked.

Table 5

**EXPECTATIONS FOR INTRODUCING A FLEXIBLE BENEFITS
OR CAFETERIA PLAN IN THE NEXT 2 YEARS**

Q: (Employers) Do you expect to introduce a flexible benefits or cafeteria plan in the next 2 years for any of your employees, or not?

	Corporate Benefits Officers						
	Total	By Region				Senior Executives	Human Resource Officers
		East	Midwest	South	West		
Base	1250	410	300	344	196	200	200
	%	%	%	%	%	%	%
Yes, expect	19	17	23	16	20	13	14
	} 33*	} 30	} 40	} 28	} 40	} 28	} 28
Already offer flexible/cafeteria plan	15	12	17	13	20	16	15
Do not expect	58	61	53	64	51	63	64
Not sure	8	10	7	8	9	10	9

*The figures to the right of the brackets represent the projected incidence of flexible benefits and cafeteria plans in two years. The projection is the sum of the current reported incidence of flexible plans and the expected introduction of these plans.

CHAPTER 2: HOW EMPLOYEES REACT TO HAVING A CHOICE OF BENEFITS

How Much Employees Like Having a Choice of Benefits

The opportunity to have some choice in the benefits which they receive is a popular right among an overwhelming majority of employees: 65% of employees say that they like it a lot, and 21% say that they like it a little. Among the remaining 13% of employees, only 2% say that they don't like having a choice of different benefits.

Certain groups of employees are more likely to be very receptive to having a choice of benefits. These include employees aged 18-29 years as compared to those aged 50 and over, female employees, employees in the West in contrast to employees in the East, and non-union employees.

As Table 7 shows, corporate benefits officers are well informed about how employees feel about having a choice of benefits. Eighty-seven percent of corporate benefits officers say their employees like having a choice of benefits at least a little, compared to the actual figure of 86% reported by employees.

Observation:

It should be noted that the differences mentioned above between demographic groups (in Table 6) are statistically significant, but in no way contradictory of the fact that majorities of all

demographic groups like having a choice of benefits a lot. These differences are, nevertheless, interesting and fairly consistent with demographic contrasts found in the Equitable Survey III. For example:

- *A regional analysis of the Equitable Survey III results found that employees in the East are less receptive to changes in their health plans and less satisfied with these plans than employees elsewhere in the nation.*

Also, corporate employers in the East reported more difficulty implementing these changes, and that the changes had been less effective than did employers in other regions—even though Eastern employers reported making the fewest changes in employee health plans.

- *Union employees are more resistant to changes in their health plans and to increased cost-sharing than non-union employees.*

However, perhaps the most important evidence in Table 6 of the popularity of flexible benefits is that there are virtually no differences in popularity between income groups. In contrast, the Equitable Survey III found that low income employees, who are much more adversely affected by increased cost-sharing, find such changes less acceptable than do other employees.

Table 6

HOW MUCH EMPLOYEES LIKE HAVING A CHOICE OF BENEFITS

Base: Those whose employers offer some choice of benefits

Q.: (Employees) How do you feel about having a choice of different benefits? Do you like it a lot, like it a little, not like it, or don't you care?

	Base	Like It a Lot	Like It a Little	Don't Like It	Don't Care	Not Sure
Total	999	65%	21%	2%	10%	1%
By Region						
East	245	65%	20%	3%	10%	2%
Midwest	270	59%	23%	3%	13%	2%
South	326	66%	22%	1%	9%	2%
West	158	74%	18%	1%	7%	1%
By Sex						
Male	652	62%	25%	3%	10%	1%
Female	347	71%	15%	1%	11%	2%
By Income						
\$15,000 or less	227	64%	22%	1%	12%	1%
\$15,001 to \$25,000	292	68%	18%	3%	11%	1%
\$25,001 to \$35,000	250	66%	22%	2%	8%	2%
\$35,001 or more	199	62%	25%	2%	9%	2%
By Age						
18-29	319	70%	17%	2%	10%	1%
30-39	324	68%	21%	2%	8%	1%
40-49	205	61%	24%	3%	10%	2%
50 or over	146	57%	26%	1%	13%	3%
By Union Membership						
Member	206	59%	26%	2%	11%	2%
Non-member	740	67%	20%	2%	10%	1%
By Type of Plan						
Contributory	625	67%	20%	2%	10%	1%
Noncontributory	363	62%	24%	2%	10%	2%
With deductible	801	65%	22%	2%	10%	2%
Without deductible	174	68%	21%	2%	9%	1%
By Acceptability of Changes in Plans						
Very acceptable	215	70%	19%	2%	9%	1%
Somewhat acceptable	270	65%	23%	2%	9%	1%
Not acceptable	114	60%	24%	7%	8%	2%

Table 7

**HOW EMPLOYERS THINK EMPLOYEES FEEL ABOUT
HAVING A CHOICE OF DIFFERENT BENEFITS**

Base: Those who describe plan as a flexible benefits or cafeteria plan

Q.: (Corporate Benefits Officers) How do you think most of your employees feel about having a choice of different benefits? Do you think they like it a lot, like it a little, that they don't like it, or don't they care?

	Corporate Benefits Officers
Base: 184	%
They like it a lot	55
They like it a little	32
They don't like it	1
They don't care	10
Not sure	3

Employee Satisfaction With Jobs, Salaries, and Benefits

Employees who have some choice of benefits report a higher level of satisfaction with their jobs, salaries and benefits than do employees who have no choice of benefits (Table 8). Among employees who have some choice of benefits: 55% say they are very satisfied with their jobs; 36% say they are very satisfied with their salaries; and 49% say they are very satisfied with their benefits. In contrast, only 45% of employees who have no choice of benefits say they are very satisfied with their jobs; only 28% of these employees say they are very satisfied with their salaries; and only 40% say they are very satisfied with their benefits. Also, fewer employees who have some choice of benefits say

they are very dissatisfied with their salaries and benefits than do employees who have no choice of benefits.

Observation:

The higher level of satisfaction among employees who have some choice of benefits could mean that employers who introduce flexible benefits may also find that they improve employee satisfaction with their jobs, salaries, and benefits.

However, it should be cautioned that employees who have choices of benefits may be more satisfied because they already had better jobs, salaries and benefits. The introduction of choice in benefits may well be an indicator of a better place in which to work.

Table 8

EMPLOYEE SATISFACTION WITH JOBS, SALARIES, AND BENEFITS

Q.: (Employees) All in all, how satisfied would you say you are with your job—very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

Q.: (Employees) All in all, how satisfied would you say you are with your salary—very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

Q.: (Employees) And how satisfied are you with all of your other benefits apart from your salary—very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied?

	Employees	
	Have Some Choice of Benefits	Do Not Have Some Choice of Benefits
Base: 1,253	999	254
	%	%
Satisfaction With Job		
Very satisfied	55	45
Somewhat satisfied	33	39
Somewhat dissatisfied	8	10
Very dissatisfied	4	5
Not sure	*	1
Satisfaction With Salary		
Very satisfied	36	28
Somewhat satisfied	46	43
Somewhat dissatisfied	12	17
Very dissatisfied	6	11
Not sure	*	*
Satisfaction With Benefits		
Very satisfied	49	40
Somewhat satisfied	35	37
Somewhat dissatisfied	11	11
Very dissatisfied	5	11
Not sure	*	—

*Less than 0.5%.

Acceptability of Changes in Health Plans: Among Employees Who Do or Do Not Have a Choice of Benefits

More employees who have some choice between benefits than employees who have no choice of benefits regard changes in their health plans as very acceptable—36% to 26%, respectively. Among employees whose health plans have changed a great deal or somewhat in the past three years, a vast majority (81%) have some choice between the benefits which they receive. But it should be emphasized that substantial majorities of both this group and those employees who have no choice of benefits find changes in their health plans at least somewhat acceptable.

The results presented in Table 10 suggest that many of the employees who have some choice of benefits first received them in the last 3 years. A majority of employers who in the last 3 years have increased cost-sharing by employees also have added new benefits to make the changes more acceptable. These changes include such flexible benefits as dental and eye care plans, 401(k) plans, a choice of two health plans, flexible spending plans in which employees can pay for certain benefits with pre-tax dollars, an HMO option, and full flexible benefits plans. The introduction of a dental plan is the new benefit most appreciated by employees.

Observations:

(1) There is a 25-point difference between the 30% of employees who say their employers have added benefits and the majorities of employers who say they have done this. This suggests that employers

who have introduced benefits to make changes more acceptable have done a poor job informing employees about these new benefits; and thus squandered an opportunity to win wider employee acceptance of increased cost-sharing, as the contrast in Table 9 between employees who do and do not have a choice of benefits clearly shows.

(2) These findings provide important supporting evidence to two major findings of the Equitable Survey III. First, a large majority of employees accept changes in their health plans, as long as cost-sharing doesn't increase too much. Employers should recognize that adding new benefits makes it easier to win employee acceptance of changes, but this alone does not account for the 79% of employees who rate the changes in their health plans acceptable.

Second, there is a strong correlation between the quality of corporate communications and employee support for changes in health plans and other benefits. Employees who feel their employers did an excellent job explaining changes are far more likely to rate changes very acceptable than are employees who feel their employers did a fair or poor job explaining changes.

Table 9

**ACCEPTABILITY TO EMPLOYEES OF CHANGES IN HEALTH PLANS MADE BY EMPLOYERS:
AMONG THOSE WHO DO OR DO NOT HAVE A CHOICE OF BENEFITS**

**Base: All employees whose health plans have
changed a great deal or somewhat**

Q.: Overall, how acceptable have the changes made by your employer been to employees such as yourself—very acceptable, somewhat acceptable, not very acceptable, or not at all acceptable?

	Base	Very	Somewhat	Not Very	Not at All
All Employees	740	34%	45%	16%	5%
By Whether or Not Employees Have a Choice of Benefits					
Have a choice of benefits	600	36%	45%	16%	3%
Do not have a choice of benefits	140	26%	44%	19%	9%

Table 10

**MOST APPRECIATED BENEFITS ADDED TO HEALTH PLANS
TO MAKE CHANGES MORE ACCEPTABLE**

**Base: All whose plans have increased cost-sharing by employees
a great deal or somewhat**

Q.: (Employees) In making changes in the health plans for employees such as yourself, did your employer also add any new benefits to make the changes more acceptable?

Q.: (Employees) What one additional benefit do you think was most appreciated and valued by employees such as yourself?

Q.: (Employers) In making changes in the health plans for your employees, did you also add any new benefits to make the changes more acceptable, or for any other reason?

Q.: (Employers) What one additional benefit do you think was most appreciated and valued by your employees?

	Employees	Corporate Employers		
		Corporate Benefits Officers	Senior Executives	Human Resource Executives
Base	624	641	107	104
	%	%	%	%
All With Added Benefits	30	55	57	55
Benefits Most Appreciated				
New dental plan	9	12	14	5
Increased dental benefits	*	1	4	2
Vision/eye care benefits	1	2	4	3
Increased outpatient benefits	*	8	7	5
Increased major medical	*	3	6	5
401(k) plan	*	3	1	0
Prescription drug coverage	1	3	2	3
Additional life insurance	1	3	1	6
Short-term disability	*	1	1	1
Long-term disability	*	1	1	1
HMO option	1	1	1	*
Increased accident coverage	*	1	—	3
Increased employer contributions	*	1	2	—
Psychiatric/drug coverage	*	1	1	2
Maternity benefits	*	1	1	2
Wellness program	*	1	—	1
Increased benefits (unspecified)	2	—	—	—
PPO option	1	—	—	—
Offered choice of 2 plans	1	—	—	—
Flexible plans	1	—	—	—
All other mentions	9	12	11	14
Not sure	3	1	1	2

* Less than 0.5%.

How Employees Rate Employers' Decision to Offer a Choice of Benefits

Employees are nearly unanimous in supporting their employers' decision to offer employees a choice of benefits. Ninety-one percent of employees who have some choice between benefits say this was at least a somewhat good decision, and a majority of 56% rate it a very good decision. Only 5% of employees say that offering a choice of benefits was not a very good decision, and 2% say it was a mistake.

However, employees who say their employers did an excellent job explaining changes are far more likely to feel the decision to offer a choice of benefits was a very good one than do employees who say their employers did a fair or poor job explaining changes. Seventy-two percent of employees who rate their employers' communications excellent say the decision was a very good one. Only 43% of employees who say their employers did a fair or poor job explaining changes feel that offering a choice of benefits was a very good decision.

Observation:

This powerful correlation between the quality of corporate communications and employee support for the introduction of flexible benefits mirrors one

of the most important findings of the Equitable Survey III. Employees who feel their employers do an excellent job explaining changes in health plans are far more likely to rate these changes very acceptable than employees who feel their employers did a fair or poor job explaining changes. This correlation is so strong that it appears good communications seems to be almost as important as the details of the changes made

The 29-point gap in Table 11 between employees who give their employers excellent versus poor marks in explaining changes in health plans and other benefits provides strong supporting evidence for this major finding of the Equitable Survey III.

Majorities of employees in every region of the country rate the decision to offer a choice of benefits a very good one, but a significantly greater proportion of employees in the West (68%) than employees elsewhere feel this way. Female employees also rate this decision more positively than males. And non-union members also responded a bit more positively than union employees, but this difference is merely consistent with a pattern of differentiation between the groups, and not statistically significant.

Table 11

HOW EMPLOYEES RATE EMPLOYERS' DECISION TO OFFER A CHOICE OF BENEFITS

Base: Those whose employers offer some choice between different benefits plans

Q.: (Employees) Overall, would you say that your employer's decision to offer employees a choice of benefits was a very good decision, a somewhat good decision, not a very good decision, or a mistake?

	Base	Very Good Decision	Somewhat Good Decision	Not a Very Good Decision	Mistake	Too Early to Say	Not Sure
Total	999	56%	35%	5%	2%	*	2%
By Region							
East	245	53%	37%	7%	2%	1%	1%
Midwest	270	51%	37%	5%	4%	*	3%
South	326	56%	36%	6%	2%	—	2%
West	158	68%	24%	4%	1%	1%	2%
By Sex							
Male	652	53%	37%	5%	3%	*	3%
Female	347	61%	31%	6%	1%	1%	1%
By Union Membership							
Member	206	52%	33%	8%	3%	1%	3%
Non-member	740	56%	35%	5%	2%	*	2%
By Type of Plan							
Contributory	625	56%	34%	6%	2%	1%	1%
Noncontributory	363	55%	36%	4%	3%	*	3%
With deductible	801	53%	37%	6%	2%	*	2%
Without deductible	174	64%	29%	3%	2%	1%	2%
By Job Done by Employers in Explaining Changes							
Excellent	184	72%	23%	2%	2%	—	1%
Good	232	55%	38%	4%	2%	*	*
Fair or poor	180	43%	39%	11%	4%	—	3%

*Less than 0.5%.

CHAPTER 3: EMPLOYER EXPERIENCES AND PERCEPTIONS ABOUT FLEXIBLE BENEFITS AND CAFETERIA PLANS AND THE PROBLEMS INVOLVED WITH THESE PLANS

Effectiveness of Flexible Benefits in Achieving Corporate Goals: Employers' Perceptions and Experiences

Both corporate benefits officers whose companies do and those whose companies do not have flexible benefits plans were asked to evaluate the effectiveness of these plans in achieving six different corporate goals. Tables 12 and 13 show that with one significant exception—controlling the cost of benefits—corporate benefits officers' perceptions about the effectiveness of flexible benefits in achieving these goals closely match the experiences of benefits officers whose companies have flexible benefits plans.

Large majorities of both those employers who don't have flexible benefits plans, and those who have seen firsthand how they work, believe they are at least somewhat effective in controlling the cost of benefits, improving benefits for employees,

meeting the needs of different types of employees, educating employees about the real costs of their benefits, improving employees' satisfaction with their benefits, and improving employee morale and loyalty.

But a gap of 21 points separates the experiences and perceptions of corporate benefits officers on the effectiveness of flexible benefits in controlling the cost of benefits. Thirty-five percent of officers who have them rate them very effective in controlling costs, compared to only 14% of officers whose employees don't have these plans. This gap is particularly significant because officers who have these plans consider controlling the cost of benefits the most important reason for having flexible benefits and cafeteria plans.

Small minorities of employers who have implemented flexible benefits plans feel they are not very or not at all effective in achieving these corporate goals.

Table 12

**PERCEIVED EFFECTIVENESS OF FLEXIBLE BENEFITS PLANS IN
ACHIEVING CORPORATE GOALS: AMONG EMPLOYERS WHO DON'T OFFER THEM**

**Base: Corporate benefits officers who describe plan as neither
a flexible benefits nor a cafeteria plan**

Q: (Corporate Benefits Officers) I will read you some reasons why some other companies have flexible benefits. Please say for each one how effective you think flexible benefits usually are— very effective, somewhat effective, not very effective, or not at all effective in actually achieving this.

Base: 1,066	Very Effective	Somewhat Effective	Not Very Effective	Not at All Effective	Not Sure
Controlling the cost of benefits	14%	49%	22%	10%	6%
Improving benefits for employees	29%	49%	13%	6%	4%
Meeting the different needs of different types of employees	53%	35%	7%	4%	2%
Educating employees about the real costs of their benefits	34%	46%	14%	5%	2%
Improving employee satisfaction with their benefits	39%	47%	9%	2%	2%
Improving employee morale and loyalty	23%	49%	19%	5%	3%

Table 13

**EFFECTIVENESS OF FLEXIBLE BENEFITS PLANS IN ACHIEVING CORPORATE GOALS:
AMONG THOSE WHO OFFER A FLEXIBLE BENEFITS OR CAFETERIA PLAN**

**Base: Corporate benefits officers who describe plan as a
flexible benefits or cafeteria plan**

Q.: (Corporate Benefits Officers) I will read you a list of reasons why some companies have introduced flexible or cafeteria benefits plans. Please say for each one if having flexibility and choice in your plans is very effective, somewhat effective, not very effective, or not at all effective in actually achieving this.

Base: 184	Very Effective	Somewhat Effective	Not Very Effective	Not at All Effective	Not Sure
Controlling the cost of benefits	35%	54%	6%	3%	2%
Improving benefits for employees	36%	54%	9%	1%	—
Meeting the different needs of different types of employees	52%	40%	6%	1%	1%
Educating employees about the real costs of their benefits	38%	45%	13%	4%	1%
Improving employee satisfaction with their benefits	39%	53%	7%	1%	1
Improving employee morale and loyalty	27%	58%	14%	2%	—

Table 14

**MOST IMPORTANT REASON FOR IMPLEMENTING A
FLEXIBLE BENEFITS OR CAFETERIA PLAN**

**Base: Corporate benefits officers who describe plan as a
flexible benefits or cafeteria plan**

Q.: (Corporate Benefits Officers) Which of these reasons that I have just read were the most important reasons for your company to have flexible/cafeteria benefits?

	Corporate Benefits Officers
Base: 184	%
Controlling the cost of benefits	40
Meeting the different needs of different types of employees	27
Improving employee satisfaction with their benefits	17
Improving employee morale and loyalty	16
Educating employees about the real costs of their benefits	14
Improving benefits for employees	11
Not sure	5

Magnitude of Problems Caused by Flexible Benefits Plans: Employers' Perceptions and Experiences

The two groups of corporate benefits officers—those whose companies do or do not have flexible benefits plans—also were asked to assess problems which accompany flexible benefits plans. Tables 15 and 16 show that corporate benefits officers' fears about the severity of problems with flexible benefits are not born out by the experiences of companies who have introduced these plans. There are immense differences between the two groups' perceptions and experiences:

- Only 14% of officers whose firms have flexible plans consider the difficulty or cost of administration a major problem, compared to 64% of officers whose firms don't have flexible plans. Furthermore, more than one-third (36%) of officers with flexible plans say that difficulty or cost of administration has not been a problem.

- Only 21% of officers whose firms have flexible plans consider the difficulty or cost of communicating details of the plans to employees a major problem, compared to 55% of officers whose firms don't have flexible plans. A significant minority (28%) of officers with flexible plans say that communicating details to employees has not been a problem.
- Only 9% of officers whose firms have flexible plans say that an increase in the **overall cost** of benefits plans as a result of introducing choices has been a major problem. Thirty-nine percent of officers whose firms don't have flexible plans believe that increases in overall costs of benefits would be a major problem. And nearly 45% of officers with flexible plans say that overall increases in costs have not been a problem.

However, employers' experiences with flexible benefits plans have not been trouble-free. About half of corporate benefits officers whose firms have flexible plans report encountering minor problems with their plans.

Observation:

The fact that so many corporate employers believe that flexible benefits plans would cause major problems perhaps explains why only 15% of employers have introduced full-fledged flexible/cafeteria plans; and why most employers seem to introduce flexible features piecemeal, even though large majorities believe that flexible benefits are very effective in controlling costs and achieving other corporate goals.

The overwhelmingly positive experiences reported by corporate benefits officers who have flexible plans—both in their effectiveness and in the manageability of problems with them—suggest that employers need not be so cautious in introducing these plans. Moreover, flexible benefits are popular with employees. It seems probable

that employers who expect to introduce flexible benefits plans to employees in the near future will also be able to implement these plans successfully, and achieve their corporate objectives—if these employers do at least a good and, preferably, an excellent job informing employees about their new benefits and explaining what they mean.

Whether or Not Offering a Choice of Benefits Was a Good Decision

The final table in this report completes the picture of employers' positive experiences with flexible benefits plans. Sixty percent feel that offering employees a choice of benefits was a very good decision, and 35% feel it was a somewhat good decision. Only 2% say that offering employees a choice of benefits was not a very good decision or a mistake.

Table 15

PERCEIVED MAGNITUDE OF PROBLEMS CAUSED BY FLEXIBLE BENEFITS PLANS: AMONG THOSE WHO DON'T OFFER THEM

Base: Corporate benefits officers who describe plan as neither
a flexible benefits nor a cafeteria plan

Q.: (Corporate Benefits Officers) There are also some possible problems with flexible and cafeteria benefits plans. Please say for each of the following if you think it is usually a major problem, a minor problem, or not a problem at all for employers with these plans.

Base: 1,066	Major Problem	Minor Problem	Not a Problem	Not Sure
The difficulty or cost of administration of the plan	64%	29%	4%	3%
The difficulty or cost of communicating the details of the plan to employees	55%	37%	6%	2%
An increase in the overall cost of the plan as a result of introducing choice	39%	48%	9%	5%

Table 16

**MAGNITUDE OF PROBLEMS CAUSED BY FLEXIBLE BENEFITS PLANS:
AMONG THOSE WHO OFFER A FLEXIBLE BENEFITS OR CAFETERIA PLAN**

**Base: Corporate benefits officers who describe plan
as a flexible benefits or cafeteria plan**

Q.: (Corporate Benefits Officers) There are also some possible problems with flexible and cafeteria benefits plans. Please say for each of the following if it has been a major problem, a minor problem, or not a problem at all for your company.

Base: 184	Major Problem	Minor Problem	Not a Problem	Not Sure
The difficulty or cost of administration of the plan	14%	47%	36%	3%
The difficulty or cost of communicating the details of the plan to employees	21%	50%	28%	1%
An increase in the overall cost of the plan as a result of introducing choice	9%	45%	45%	2%

**DIFFERENCES BETWEEN THE EXPERIENCES OF EMPLOYERS WHO OFFER
FLEXIBLE AND CAFETERIA PLANS AND THE PERCEPTIONS OF
EMPLOYERS WHO DO NOT OFFER THEM (Table 16 figures - Table 15 figures)**

Base: 184	Major Problem	Minor Problem	Not a Problem	Not Sure
The difficulty or cost of administration of the plan	-50%	+18%	+32%	-
The difficulty or cost of communicating the details of the plan to employees	-34%	+13%	+22%	-1%
An increase in the overall cost of the plan as a result of introducing choice	-30%	-3%	+36%	-3%

Table 17

**WHETHER OR NOT EMPLOYERS FEEL OFFERING EMPLOYEES A CHOICE
OF BENEFITS WAS A GOOD DECISION**

**Base: Corporate benefits officers who describe plan
as a flexible benefits or cafeteria plan**

Q.: (Corporate Benefits Officers) Overall, would you say that your company's decision to offer employees a choice of benefits was a very good decision, a somewhat good decision, not a very good decision, or a mistake?

	Corporate Benefits Officers
Base: 184	%
Very good decision	60
Somewhat good decision	35
Not a very good decision	1
Mistake	1
Too early to say	1
Not sure	1

APPENDIX: SURVEY METHOD

Sample Design

The following separate samples were used in this study:

Employees of corporations with 500 or more employees. A nationwide cross-section of 7073 adults was screened in order to locate a representative sample of 1,253 employees. The initial sample was generated by random-digit dialing, based on an unclustered sampling frame, stratified by region and by the Census Bureau's "size of place" designations.

Employers. Three separate samples of employers were interviewed. Three systematic samples of corporations were drawn from the Dunn & Bradstreet listing of corporations with 500 or more employees in the U.S.

- One sample of corporations was used to generate **1,250 corporate benefits officers**.
- A second sample of corporations was used to draw a sample of **200 senior executives** (executive vice president level or above).
- A third sample was used to draw a sample of **200 senior human resource executives**.

Each of these three samples was drawn separately, and should not be aggregated. While each sample is projectable to its universe, the aggregate would not be representative of any universe.

Brokers and Consultants. Interviews were completed with 110 senior executives working in insurance brokerage firms and consulting firms.

- Forty of these interviews were with senior employee benefits experts in the head offices and regional offices of the ten largest brokerage firms.
- Forty of these interviews were in 40 of the larger medium-sized insurance brokerage firms.
- Ten interviews were with group health insurance consultants in the larger accounting firms, and 20 interviews were with group health insurance consultants in consulting firms.

These 110 interviews were drawn selectively with key individuals targeted in the larger firms in each segment. Unlike the samples of employees and employers, this is not a strict probability sample and the replies of the consultants cannot be projected to be accurately representative of all brokers and consultants. The findings for this sample are, therefore, indicative and not definitive.

Interviewing

All interviews were conducted by telephone from the New York offices of Louis Harris and Associates, during February and March 1985. The employee sample was interviewed at home from 5 P.M. to 10 P.M. (local time) on weekdays, and from 10 A.M. to 10 P.M. (local time) on weekends. The employer/broker and consultant samples were interviewed on weekdays from 9 A.M. to 5 P.M. Where necessary, appointments were made to interview the relevant individual within the organization contacted.

Up to three callback attempts were made to reach all selected respondents.

Questionnaires

Three questionnaires were developed for this survey: one for employees, one for employers (corporate benefits officers, senior executives, and human resource executives), and one for brokers/consultants. Many of the questions were very similar, with employees answering questions about themselves, employers answering questions about their employees, and brokers/consultants answering questions about the companies which they advise and work with. Copies of the questionnaires can be obtained from Louis Harris and Associates.

Data Processing

The editing, coding, and data processing of all questionnaires were conducted by Louis Harris and Associates.

Codes were developed for responses to open-end questions, with only those responses given by less than 0.2% of the respondents being coded as "other" responses.

The data were analyzed and tabulated separately for each of the five samples.

Sampling Error

The table below indicates the sampling error associated with the various samples sizes and the reported sample percentages at the 95% confidence level:

REPORTED SAMPLE PERCENTAGE					
Sample Size	10% or 90%	20% or 80%	30% or 70%	40% or 60%	50%
1,250	2%	2%	3%	3%	3%
200	4%	5%	6%	6%	7%
110	6%	8%	9%	9%	10%

DEMOGRAPHIC PROFILE OF THE EMPLOYEE SAMPLE

	%
All Employees	100
Region 1	
East	25
Midwest	27
South	34
West	15
Sex	
Male	66
Female	35
Employer's Business	
Manufacturing	47
Wholesale, retail	11
Financial	11
Service	17
Other	15
Income	
\$15,000 or less	25
\$15,001 to \$25,000	28
\$25,001 to \$35,000	25
\$35,001 or more	19
Age	
18-29 years	31
30-39 years	32
40-49 years	21
50 or over	16
Labor Union	
Self	23
Other in family	5
No one	72
Family Size Covered	
1	29
2	23
3 or more	47

1

Definition of Geographic Regions Used by Louis Harris and Associates:

East: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania, Delaware, Maryland, District of Columbia, and West Virginia.

South: Virginia, North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Texas, and Oklahoma.

Midwest: Ohio, Michigan, Indiana, Illinois, Wisconsin, Minnesota, Iowa, Missouri, Kansas, Nebraska, South Dakota, and North Dakota.

West: Montana, Wyoming, Colorado, New Mexico, Arizona, Nevada, Utah, Idaho, California, Oregon, and Washington.

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